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CONTENTS

ORIGINAL PAPERS

The Diagnosis of Peritonitis in the Unconscious Patient — 1 — HILARY H. TIMMIS, M.D.

Cerebral Dysfunction: Clues to Neurological Disorders in Children — 8 — J. T. JABOUR, M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXI — 6 — ROBERT R. SURRATT, M.D.

Professional Dilemma: Tax Equity Through Corporate Structure? — 12 — ROWLAND B. KENNEDY

EDITORIALS

Tempest in the Memphis Hospitals: A Call for Statesmanship — 19 — No Pay, No Care

Minimum Wage and Hospital Charges — 20 — Cost Line Challenged

Mary Mallon, Forgotten Figure of History — 21 — Every Doctor Knows Her

From Washington to Ann Arbor—Not Retirement — 21 — It's Professor Cohen

Test Yourself on Your Health Insurance — 22 — You'll Flunk This Test

THIS MONTH

The President Speaking — 18 — Positive With Prevention

Medical Organization — 27 — Coronary Drug Study

Meetings — 17 — Society Circuit

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NIH Will Sponsor Rubella Conference

An International Conference on Rubella Immunization will draw scientists throughout the world to the National Institutes of Health, Feb. 18-20, to discuss the latest results of rubella vaccine research and to consider the prospects for controlling this virus disease.

Invitations have been extended to several hundred investigators in the fields of virology and immunology to attend the meeting in the Clinical Center Auditorium at NIH's Bethesda, Maryland, campus. The National Institute of Allergy and Infectious Diseases (NIAID) and the Division of Biologics Standards (DBS)—two components of the NIH—are sponsoring the meeting.

Dr. Saul Krugman, professor and chairman of the department of pediatrics at New York University School of Medicine, will be conference chairman. Dr. Krugman, a member of NIAID's Advisory Committee for Vaccine Development, has long conducted research on rubella (or German measles) and with his colleagues has conducted trials of experimental vaccines to control childhood diseases.

The conference will deal with all aspects of rubella: the disease, the virus which causes it, epidemiology, studies with experimental vaccines and human gamma globulin, the production of vaccines and biologics control.

In 1965, two DBS scientists, Drs. Harry M. Meyer, Jr. and Paul D. Parkman, developed and tested the first successful experimental live attenuated rubella vaccine. Today, full scale testing of their vaccine virus (HPV-77), derivatives of HPV-77, and other attenuated rubella viruses are being conducted by medical centers under contract to the NIAID Vaccine Development Program and by pharmaceutical firms. All are seeking a vaccine which could be licensed and produced in time to prevent a recurrence of the 1964-65 rubella epidemic, which produced some 30,000 abnormal pregnancies. If the current trials bear out early successes and licensing is granted, a vaccine could be available for the public by 1969.

Members of the program committee for the conference, in addition to Dr. Krugman, will be Dr. Edwin H. Lennette of the California State Department of Public Health; Dr. Frederick Rob-

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bins of Case Western Reserve University; Dr. W. Charles Cockburn of the World Health Organization, Geneva, Switzerland; Dr. Thomas Weller of Harvard University; Dr. Bruce Dull of the National Communicable Disease Center, Atlanta, Ga.; Drs. Meyer and Parkman, DBS; and Drs. Daniel Mullally and Earl Beck of NIAID.

AAP Reports Study of Safety Closures

Significant progress toward developing standard performance tests for safety closures used on medicine bottles and other types of containers has been announced by the American Academy of Pediatrics.

Results of a study which tested 72 adults and 72 children who used snap-off, Palm-N-Turn, and press-and-turn closures, as well as a standard screw top closure, indicated that the Palm-N-Turn and press-and-turn closures were so effective, that practically none of the children tested could remove these closures even though the method for opening them was demonstrated.

Significantly only 22 of 36 healthy adults could open these closures without demonstrations.

Results of the study were reviewed at the AAP meeting by a national committee to develop standards for safety closures for aspirin and other medicine. The study was financed by the Proprietary Association, and conducted by the Biological Science Laboratories of Foster D. Snell, Inc.

Dr. Edward Press, Oregon State Health Officer and chairman of the committee, emphasized that results of this study, and two other studies, represent a significant step toward developing safer and more reliable closures for medicine bottles and other containers which can constitute safety hazards for children. He also pointed out that an expansion of the study to check on its reproducibility and uniformity would be required before any formal recommendations can be made.

The committee to develop standards for safety closures has been appointed by the Food and Drug Administration of the U. S. Department of Health, Education, and Welfare to enable industry and regulatory agencies to jointly develop recommendations for standards.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

January 1969

Dear Doctor:

Retiring Secretary of HEW Wilbur J. Cohen has bluntly warned the medical profession to control professional fees. Appearing on a pre-Christmas airing of NBC's "Meet the Press," Cohen said that the profession's course of action during next 18 months will determine whether federal controls over fees come into being.

> The warning omitted any reference to zooming hospital charges, despite a rise twice that of medical fees. Cohen said that unless physicians restrained fees voluntarily, Congress would institute controls.

Death from accidental falling was second only to motor vehicle fatalities as the toll of trauma in U. S. last year. Metropolitan Life studies showed that 20,000 Americans died from fall-sustained injuries and another 12 million were injured in some degree. About three million with back and limb impairments were hurt in falls.

Chalk up another Russian first: A Soviet naval physician removed his own appendix while on submarine duty in the Pacific. Tass, the Russian news service, said that Capt. Alexei Shapolvalov took out his own appendix under local anesthetic, using a mirror, when he found that the submarine couldn't make it back to port in time. Tass said it was the first in a submarine.

New York City has adopted a drastic anti-air pollution plan which gives Mayor Lindsay authority to shut down industry and traffic. On warning from environmental monitor stations, mayor may order "forecast" stage which halts home rubbish incineration. Next is "alert," closing city dump burning, and "warning" closes half of industries. "Emergency" stage halts auto traffic. System has not yet been used.

UAW President Walter P. Reuther has fired the opening gun in his quest for universal compulsory federal medical care. He has organized the Committee for National Health Insurance which will seek Medicare for all citizens. Dr. Michael DeBakey and Mrs. Mary Lasker are vice chairmen.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

New B. S. Practitioner Is 'Pediatric Associate'

New York - The Carnegie and Commonwealth foundations have jointly announced $500,000 support of a new professional practitioner training program at the University of Colorado, a B.S. degree pediatric associate. The new practitioner will independently make diagnoses, write Rx's except for narcotics, treat patients, and give immunizations under physician supervision. Unlike other "associates," he will be oriented to a physician's work instead of nurse's work. Colorado Medical Society, backing program, will seek state legislation for licensure and legality of practice.

ACS Will Establish Transplant Registry

Chicago - The American College of Surgeons, at the request of the National Institutes of Health, will establish and maintain a registry of human transplant cases in the United States. Registry will be housed in ACS Chicago headquarters and supervised by a transplant coordinator. Cases will include transplants of heart, liver, lungs, spleen, pancreas, thymus, gonads, and bone marrow. Kidney transplants, already monitored effectively and separately, will not be included. Objectives are to have reliable biologic data, to share information, and to avoid repetition of misadventures.

TV And Radio Spots Are Hitting Fag Fatalities

Jackson - The Mississippi Heart Association reports new successes in TV and radio spot announcements discouraging smoking of cigarettes. Some heart association efforts are joint enterprises with American Cancer Society. Color TV spots are said to be particularly effective, especially the one minute color movie, "The Cough."

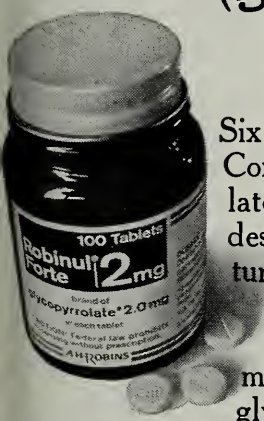
Need For Emergency Identification Is Underscored

Chicago - AMA says that 40 million Americans have hidden medical problems which may not be recognized in medical emergencies, and each could benefit from wearing the emergency medical identification symbol. Device, with internationally recognized symbol, should be worn about patient's neck or wrist and should specify problems, such as diabetes, epilepsy, or allergies. AMA supplies lists of 30 commercial distributors on request.

Physician Has Intensified Role In Sex Counseling

Raritan, N.J. - Many more Americans, especially teenagers and wives, are turning to physicians for sex counseling than they did five years ago. This is the finding of a study done by Ortho Pharmaceutical Corp. which reports that physicians are finding an increase in sexual problems by reason of psychological bases. Younger physicians say this is true, but older physicians lay emphasis on ignorance of patients.

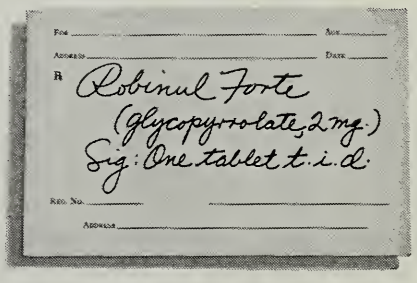
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However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

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The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

AAP Wants Hearings on Head Start Shift

The American Academy of Pediatrics has strongly urged that further legislative action be deferred on a proposed amendment to transfer Head Start until public hearings can be held, and the amendment can be studied more carefully by both the Senate and the House.

The U. S. Senate, on July 17, passed an amendment attached to the Vocational Education Bill, which if approved by the House of Representatives, would transfer administration of the Head Start program from the Office of Economic Opportunity to the Office of Education.

Reviewing the Senate-passed amendment, the Academy statement emphasized that important components of the Head Start program would be neglected if the amendment, as presently constituted, were adopted.

The Academy indicated, for example, that the amendment does not safeguard the family-centered nature of the Head Start programs, nor does it call for a comprehensive approach toward the developmental needs of children.

The AAP further stated that the amendment fails to assure funding for community action agencies which have been established, and which guarantee parent participation in Head Start.

"The Academy has serious reservations about a program aiming to help children function at optimal levels which does not take into account the family needs and diverse developmental needs of children in the social, psychological, as well as cognitive areas," the statement emphasized.

"Head Start must be more than simply a kindergarten program. Parent participation in planning and operations should be included in order to insure effective environmental change in impoverished families."

The AAP pointed out that the amendment does not satisfactorily assure that nutritional, health, and other programs designed to meet additional needs of children will be given supportive or consultative help.

Finally, the AAP statement cited the amendment's insufficient provision for discretionary review of individual Head Start programs at the Federal level.

Announcing the Thirty-Second Annual Meeting of
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Conference Headquarters—Roosevelt Hotel—March 10, 11, 12, 13, 1969

GUEST SPEAKERS

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Anesthesiology
Norman D. Nigro, M.D., Detroit, Mich.
Colon and Rectal Surgery
Rudolf L. Baer, M.D., New York, N.Y.
Dermatology
W. H. J. Summerskill, M.D., Rochester, Minn.
Gastroenterology
Edward J. Kowalewski, M.D., Akron, Pa.
General Practice
John G. Masterson, M.D., Hines, Ill.
Gynecology
Ray W. Gifford, Jr., M.D., Cleveland, Ohio
Internal Medicine
Raymond V. Randall, M.D., Rochester, Minn.
Internal Medicine
Wlliam J. German, M.D., New Haven, Conn.
Neurosurgery
Robert A. Kinch, M.D., Montreal, Que.
Obstetrics
John R. Lynn, M D., Dallas, Tex.
Ophthalmology
A. B. Sirbu, M.D., San Francisco, Calif.
Orthopedic Surgery
Douglas P. Bryce, M.D., Toronto, Ont.
Otorhinolaryngology
A. James French, M.D., Ann Arbor, Mich.
Pathology
Louis Gluck, M.D., Miami, Fla.
Pediatrics
Wilma C. Diner, M.D., Little Rock, Ark.
Radiology
James D. Hardy, M.D., Jackson, Miss.
Surgery
John W. Kirklin, M.D., Jackson, Miss.
Surgery
Russell Scott, Jr., M.D., Houston, Tex.
Urology

Additional speaker to be announced.

Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives. (All-inclusive registration fee—$30.00.)

This program is acceptable for three and one-half (3½) prescribed hours and twenty-eight (28) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1969, Vol. X, No. 1

ORIGINAL PAPERS

The Diagnosis of Peritonitis In the Unconscious Patient

HILARY H. TIMMIS, M.D.
Jackson, Mississippi

FOLLOWING A REVIEW of the general surgical literature and the standard surgical texts, one might conclude that the initial simultaneous association of coma and peritonitis is a relatively rare phenomenon. However, the combined presence of these two morbid events derives much significance from the fact that it represents a major, although poorly publicized, diagnostic challenge which, if unrecognized, will almost invariably result in death.

While frank coma and peritonitis presenting together as manifestations of a single disease entity is uncommon, peritonitis complicating the comatose state or the onset of coma as a terminal sign of uncontrolled peritoneal sepsis is not. Moreover, the presence of peritonitis in the uncommunicative patient for reasons of age, intoxication, senility, or mild to moderate central nervous system depression is commonly met. There are a variety of clinical instances gleaned from our own experience as well as from the literature (Figure 1) in which peritonitis and coma may be associated, beginning together or following one after the other.[1–4]

Whatever the cause and sequence, the problem of diagnosis in this broad group rests on the fact that one is unable to reliably elicit the cardinal manifestations of peritoneal irritation which are characterized by abdominal pain, rigidity, or involuntary guarding and tenderness. Consequently, one must rely mainly upon secondary signs and laboratory examinations. In all instances, the keystone of diagnosis is a high index of suspicion despite the absence of cardinal signs.

The combined presence of coma and peritonitis represents a major diagnostic challenge which, if unrecognized, will almost always result in death. Diagnosis rests on a high index of suspicion, followed by a systematic and complete physical examination, the orderly application of widely available diagnostic laboratory determinations, and, finally, by repeated first-hand clinical observation.

Frequently, the spark of suspicion is first ignited by a critical review of the historical aspects of each case. When the patient is admitted in a comatose state, those most closely associated with him at home must be carefully interviewed and this may direct one's thoughts to an intra-abdominal catastrophe. Similarly, when peritonitis intervenes in the hospitalized, unconscious patient, an appraisal of the preceding hospital course including vital signs, intake and output, laboratory measurements and daily obser-

From the Department of Surgery, University of Mississippi School of Medicine.

vation is essential. The suspicion of intra-abdominal disease producing a change in the expected course may thereby be aroused.

SIMULTANEOUS PERITONITIS AND COMA

- Trauma
 CNS injury with rupture of GI or GU hollow viscus, biliary tree or pancreas
- Mesenteric and cerebral arterial occlusion
 Embolus
 Thrombotic thrombocytopenic purpura
- Poisoning—heavy metals, etc.
- Cirrhosis—(hepatic coma)
 Gastroduodenal perforation
 Primary peritonitis

Figure 1

The heralding physical signs in this group are commonly fever due to sepsis or the absorption of bacterial toxins or products from the peritoneal cavity, tachycardia, and peripheral vascular instability resulting from the large fluid dislocations that occur. In the absence of primary cardiac dysfunction, a labile systemic arterial pressure should be associated with a falling central venous pressure. The reduction of extracellular volume due to third space loss within the peritoneal cavity and edema of the serosal surfaces is quickly reflected by a fall in urinary output and eventually the stigmata of dehydration.

ABDOMINAL EXAMINATION

Examination of the abdomen is variable depending upon the level of consciousness and the nature and duration of the morbid intraperitoneal process. At lighter levels of consciousness, guarding and rigidity may be elicited and are usually associated with some reaction to painful stimuli. In deep coma, paralleling anesthetic planes 3 or 4, these signs will be absent. Auscultatory appraisal of the abdomen may reveal hyperactive borborygmus simulating mechanical obstruction early in the course of mesenteric occlusion. Conversely, tinkling, hypoactive or absent bowel sounds characterize the partial or complete ileus which occurs with extending intraperitoneal contamination and sepsis. Abdominal distention, in turn, is commensurate with the magnitude of reflex ileus and passive dilatation of the intestine in which gas and fluid are sequestrated. In some instances of localizing peritonitis, edema of the abdominal wall adjacent to an intra-abdominal inflammatory mass may be present or a fluctuant mass may be identified during rectal examination.

LABORATORY EXAMINATION

The second line of diagnostic defense rests on blood and serum examinations. The hemoglobin and hematocrit are commonly elevated in early peritonitis due to the rapid reduction of circulating plasma volume. Later in the course of the disease, a falling hematocrit reflects severe septic bone marrow depression. In most instances, the WBC will be elevated above 12,000 and a much higher count may be seen, particularly when non-viable bowel is present. However, in the presence of overwhelming sepsis and at the extremes of age, the count may be normal or reduced.

In these cases the differential count is of particular significance since it frequently will indicate bone marrow stress characterized by the release of immature leukocytes, polymorphonuclear bands on down, the so-called shift to the left. The serum amylase which is most helpful in the diagnosis of acute pancreatitis may also be elevated with gastroduodenal perforation, inflammatory lesions of the biliary tract and small bowel obstruction. The serum bilirubin is also commonly elevated in inflammatory biliary tract disease in the absence of bile leakage or clinical icterus. Prerenal azotemia characterized by mild to moderate elevations of the blood urea nitrogen may occur due to rapid dehydration and may be identified by the inordinately low serum creatinine and rapid correction following rehydration.

The electrolyte pattern which is first seen is largely dependent upon antecedent symptoms. Severe vomiting is commonly complicated by hypochloremic, hypokolemic alkalosis, whereas, significant diarrhea tends to produce a hyperchloremic, metabolic acidosis. However, the peritoneal inflammatory response, per se, results in a loss of water containing all ions at physiologic levels so that no electrolyte aberration may be demonstrable in the extracellular compartment.

RADIOLOGIC EXAMINATION

Armed with presumptive physical and laboratory evidence of an inflammatory response possibly situated in the abdomen, it is imperative that x-ray examination of the abdomen be performed and this may yield considerable information.

Ileus characterized by dilatation of the small and large bowel may be noted in the supine abdominal film (Figure 2). Its inflammatory character is suggested by increased space between the radiolucent loops of bowel, which may result from edema of the bowel wall, an increased fluid content within the bowel lumen, or separation of intestinal loops by intraperitoneal fluid (Figure 3). Dimming or absence of the psoas shadows suggests the presence of free intraperitoneal fluid or at least an increased fluid content within the small bowel (Figure 4). The decubitus film in the unconscious patient is useful in identifying free air within the peritoneal cavity and the presence of static fluid levels within the adynamic intestinal loops (Figure 5). If one is able to obtain an upright film of the abdomen, the changes seen in the decubitus film are present more dramatically.

CONTRAST STUDIES

A variety of contrast studies may be helpful in pinpointing the etiology of peritonitis. Some of the more obvious include the upper GI study, the small bowel series and the barium enema.

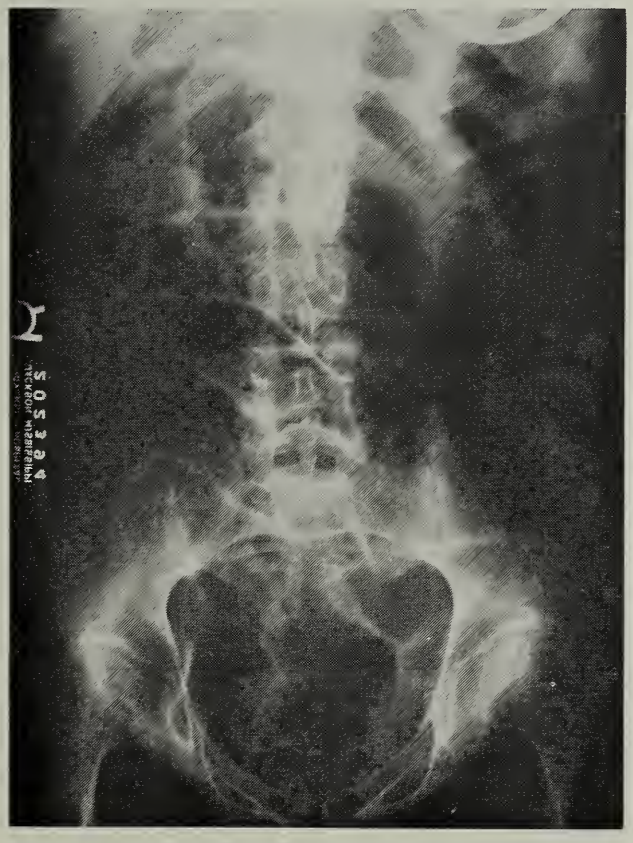


Figure 2. Generalized dilatation of the small bowel and colon, which is characteristic of adynamic ileus, may be demonstrated in the supine abdominal film.



Figure 3. The discrete separation of adjacent segments of the GI tract results from varying degrees of edema, free intra-peritoneal fluid and increased fluid content within the small bowel.

Examination of the stomach and duodenum, at least with a water soluble medium, may be used to diagnose gastroduodenal perforation in the absence of pneumoperitoneum as well as displacement of the stomach by an adjacent collection or inflammatory mass. The contrast study of the small bowel may be similarly used to appraise perforative and non-perforative lesions of the small intestine. The barium enema is particularly useful in evaluating the presence of diverticulitis, carcinoma, and stercoral ulcer, all of which may perforate producing localized or generalized peritonitis. If rupture of the bladder secondary to trauma is suspected, a cystogram will usually demonstrate extravasation of contrast material into dependent regions of the peritoneal cavity and accentuation of spaces between intestinal loops (Figure 6).

DIAGNOSTIC PARACENTESIS

When an intra-abdominal catastrophe is suspected in the unconscious patient, diagnostic paracentesis is warranted to help focus upon the etiological spectrum.[5] However, this should be

carried out only after x-ray examination so that the inadvertent passage of air into the peritoneal cavity does not mistakenly lead to a diagnosis of free perforation. The peritoneal tap is useful to identify the characteristics of free abdominal fluid as well as the presence of bacterial contamination. The procedure can be performed with reasonable safety with a #16 Angiocath or some other flat beveled needle to avoid penetration of the bowel. When the outer plastic cannula has entered the peritoneal cavity, the inner metal needle stylet is removed, further decreasing the likelihood of intra-abdominal injury.

EXAMINATION OF ASPIRATE

The physical character of the aspirate is sometimes helpful in diagnosis. A colorless, odorless turbid fluid may occur with any intra-abdominal inflammatory lesion. In the upper GI tract, perforation may be present or absent while in the distal small bowel or colon, perforation if present is usually either closed or walled off. Frank pus usually indicates the presence of a perforated hollow viscus of more extended vintage and the association of a fecal odor tends to place it below the level of the appendix. Bloody aspirate may result from intra-abdominal trauma,



Figure 4. The sequestration of fluid within an adynamic small bowel and/or large volume of free intra-peritoneal fluid usually diminishes or obliterates the psoas shadows.

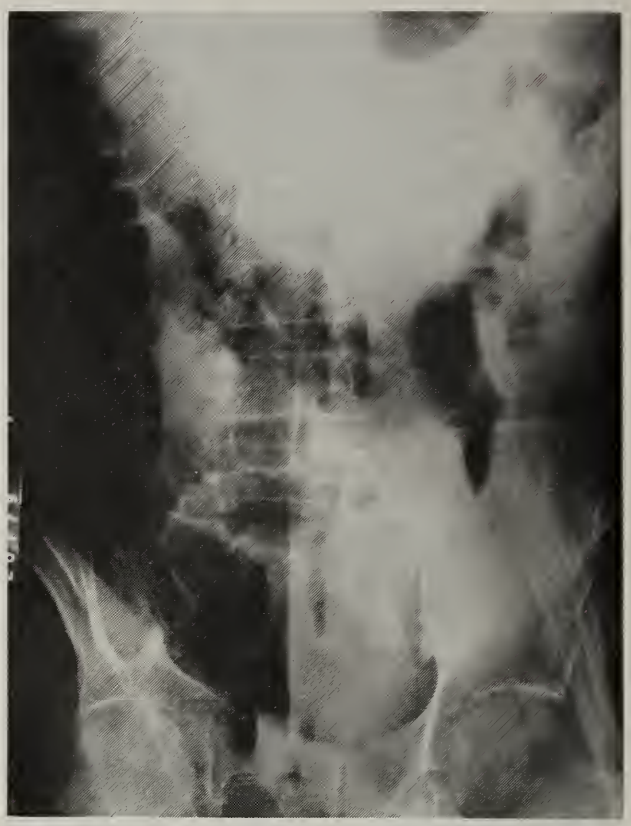


Figure 5. The left lateral decubitus film is helpful in demonstrating free peritoneal air and air fluid levels when the upright position cannot be used.

recently compromised loop of bowel, or possibly, hemorrhagic pancreatitis. A violatious, foul smelling aspirate indicates the presence of infarcted bowel which has been present for several hours.

OTHER LAB PROCEDURES

Chemical determinations upon the aspirate may yield additional information. The amylase level should be markedly elevated with acute pancreatitis but may also be high in other clinical instances such as gastroduodenal perforation. Significant bacteriologic data, in turn, can be obtained immediately by Gram stains of a scant quantity of the aspirate. In addition, leukocytes can also be detected. The presence of a large number of rod forms is more commonly seen with perforation below the ligament of Treitz, whereas, predominately coccal forms are seen with higher perforations in the GI tract.

An extension of the paracentesis consists of



Figure 6. Rupture of the urinary bladder can be demonstrated during cystography by extravasation of contrast material into the peritoneal cavity and the accentuation of spaces between the intestinal loops.

the introduction of an endoscope into the peritoneal cavity followed by the introduction of air and examination of the abdominal viscera. Peritoneoscopy, as the procedure is termed, finds its greatest application in the evaluation of hepatic and biliary tract disease and the diagnosis of abdominal cancer.[6] However, it has also been used extensively to evaluate other intra-abdominal pathology in the critically ill patient. While the primary site of pathology may not be identified, it allows examination of the serosal surfaces for inflammatory changes and the collection of loculated peritoneal fluid.

SURGICAL DIAGNOSIS

Exploratory laporotomy remains the ultimate diagnostic maneuver and should be used when peritonitis suggested by other examinations threatens the life of the comatose patient.[7] The risk of surgery according to our neurosurgical colleagues is not appreciably increased if the brain stem is undamaged, provided the level of consciousness is stable. The major threats to the safe conduct of surgery in this type of patient, as in all others, are the presence of uncorrected hypovolemia, hypoxia, and hypotension. A centrally placed incision should be used to permit access by simple extension if necessary to all parts of the peritoneal cavity.

PERITONEAL IRRITATION

A discussion of this sort would be incomplete without mentioning some disease entities which can simulate and may produce signs of marked peritoneal irritation, in the absence of an intraperitoneal inflammatory process. Included among these are the abdominal crises of uncontrolled diabetes, porphyric crises, transverse myelitis, tabetic crises, acute pyelonephritis, renal calculus, sickle cell crises, lower lobe pneumonitis and acute hepatic congestion secondary to heart failure, to mention only a few.

In summary, the diagnosis of peritonitis in the unconscious patient rests on a high index of suspicion occasioned by careful examination of whatever historical features are available, followed by a systematic and complete physical examination, the orderly application of widely available diagnostic laboratory determinations, and, finally, by repeated first-hand clinical observation. ★★★

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Radiologic Seminar LXXXI: Upper Esophageal Webs

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OF THE MANY UPPER esophageal roentgen entities, webs or bands are the most difficult to document. During swallowing, barium rapidly passes through the upper esophagus and thin web-like structures are seldom seen with conventional flouroscopy. Spot films timed with the hypopharynx and upper esophagus fully distended with barium demonstrate webs quite well. Fluoro-



Figure 1. Barium swallow with frontal projection.



Figure 2. Barium swallow with lateral projection of a cervical esophageal web, largely from the anterior esophageal wall. The prominent cricopharyngeal muscle posteriorly is unrelated but in conjunction with the web increases the degree of obstruction.

Sponsored by the Mississippi Radiological Society.

scopic image intensifiers and cineradiology make discovery and demonstration much easier. Direct visualization by esophagoscopy is also diagnostic.

Radiographically these webs are most often single, shelf-like membranes arising horizontally from the anterior esophageal wall. The postcricoid area of the cervical esophagus is the most common location. Rarely they occur within the hypopharynx. Below the web there may be a segment which is slightly narrow and rigid. A second band may appear at the lower border of this area. Varying degrees of obstruction may be encountered. The etiology and pathogenesis is obscure.

There is a somewhat confused relationship between esophageal webs and the syndrome of dysphagia and anemia (Plummer-Vinson syndrome in America and Brown-Kelly-Paterson syndrome in Britain). Webs are no longer considered an essential part of this syndrome as the presence or absence of anemia, dysphagia, and webs may occur in any combination.

In management it is well to exclude other gastrointestinal pathology. Esophagoscopy should be performed for divulsion of the webs which may or may not relieve dysphagia and also to exclude a concomitant tumor. Specific antianemic therapy for the type of anemia found should be instituted. As esophageal, pharyngeal and buccal neoplasms have been reported as late sequelae, continuous follow-up studies are indicated. ★★★

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FOO†NOTES

These are actual quotations from published scientific articles, culled by the editors of the *SK&F Psychiatric Reporter*. The pithy comments are also those of the editors:

"There was little difference between the sex of the two groups of patients. About half of all of them were male."

It's that other half we'd like to hear about.

"The deceased was a 40 year old alcoholic still having enough strength to abuse the young intern on duty with curses and wild blows."

Vigor mortis?

"The drug was withdrawn for lack of ineffectiveness."

The FDA gets fussier all the time.

"Perhaps an unmarried parent becomes one when the relationship is with a partner whose attributes foster sexually changed relationships."

You won't get any argument from us.

Cerebral Dysfunction: Clues To Neurological Disorders in Children

J. T. JABBOUR, M.D.
Memphis, Tennessee

PARENTS, EDUCATORS, psychologists, and communities continue to rely on the physician regardless of his medical interest to help each individual find educational placement, social acceptance, and work or professional success in present day society. Every physician realizes, from medical student, intern, and resident experiences at the bedside, that the basic understanding of clinical neurological problems is based on sound neuroanatomical correlation.

Continued review of neurological disorders as they relate to this alteration of neuroanatomical function is imperative when the physician encounters these common learning, language, behavior, and convulsive disorders. This is a review of these subtle, but quite puzzling, diagnostic problems and the difficulties encountered when management and disposition is sought in most communities, either large or small.

Cerebral dysfunction includes several chronic neurological disorders, which can be specifically identified, and which the physician must understand (Table 1). These disorders are frequently interrelated, one disorder appearing during the early years and another in later years. For example, behavior and language disorders may appear in a child between 2 and 3 years of age while a motor disorder may become prominent at 6 to 7 years of age when the child is learning to play sports. Learning disorders may not become evident until he is 8 and 9 years of age, when reading, writing, and arithmetic are part of his school work. This disorder is related to the age when cerebral functions appear which serve these various learning, behavioral, language, and motor skills. Certainly, other areas of the cerebrum are also involved.

Pediatric Neurologist, LeBonheur Children's Hospital.
Read before the Section on EENT, 100th Annual Session, Jackson, May 13-16, 1968.

It is well known that behavior problems frequently accompany many disorders and are commonly seen in children with mental retardation, cerebral palsy, and convulsive disorders. Physicians, educators, psychologists, and parents feel the need to help the child understand the problem, while the parents seek and learn to help the child in every way. Although these problems were initially thought to be related to pressures in the home, school, or community, which placed the origin on psycho-social and environmental factors, it is now believed that the role of the brain in such behavior, learning, language, and motor disorders contributes more to these problems. Thus, the need for an understanding of the relationship of the brain to behavior is essential to the physician.

A basic understanding of clinical neurological problems is based on sound neuroanatomical correlation. Continued review of neurological disorders as they relate to this alteration of neuroanatomical function is necessary when the physician encounters these common learning, language, behavior, and convulsive disorders. The author reviews the common disorders of cerebral dysfunction stressing recognition, management and reasons for appropriate evaluation and disposition.

While many known or suspected brain injuries may result in these problems, both neurological or psychological causes may occur in the child. It is the purpose here to discuss those that are frequently related to identifiable causes which are time related to the problems. Often poorly defined birth or postnatal trauma to the head or

TABLE 1

DISORDERS OF CEREBRAL DYSFUNCTION IN CHILDREN

Disorders	*Age*	*Clinical Signs*	*Behavioral Signs*	*Neurological Signs*
Hyperactive behavior syndrome	3-8 years	Short attention span	Distractible	Choreiform movements
		Clumsy	Impulsive	Incoordination
		Overtalkative	Emotional lability	Ataxia
		Limited speech	Aggressive	Perseveration
		Poor school work	Destructive	Hyperreflexia
			Perseverative	Altered muscle tone
Language disorders	2-5 years			
Articulation defect		Improper word sounds	Hyperactive	Altered deep tendon reflexes
Expressive	5-9 years	Poor speech	Restless	Altered muscle tone
(Motor)		Limited vocabulary	Impulsive	Hemiparesis
			Perseveration	Strabismus
				Follows instructions poorly
Receptive		Understands poorly		
(Sensory)		Repeats simple commands		
Neuromotor disorders	2-6 years	Clumsy	Restless	Choreiform movements
Extrapyramidal		Grimacing	Distractible	Incoordinated
Cerebellar		School problems	Withdrawn	Altered muscle tone
Pyramidal		Runs and throws ball poorly		Hyperreflexia
				Hyperreflexia
Learning disorders		Poor reading	Perservation	Normal visual acuity
Dyslexia (reading problems)	6-10 years	Omits letters and words	Impulsive	Altered muscle tone
		Reverses letters and numbers	Restless	Mixed dominance
		Slow school performance		
Dyscalculia		Poor arithmetic	Daydreams	Incoordination
Dysgraphia		Poor writing	Short attention span	Choreiform movements

body, viral or bacterial infections or systemic infections may be found in the children. Structural brain defects may also contribute in a small number of patients. Toxic and metabolic disorders infrequently result in cerebral injury. In many instances, probably 40 per cent of the patients, the cause of the disorder is unknown. Heredofamilial factors must also be considered but are often difficult to establish.

BRAIN AREA DISTURBANCES

Cerebral dysfunction is related to disturbances of brain areas which serve behavior, learning, language, and motor functions. Neurophysiological studies in both man and animal have contributed much to the understanding of the brain and behavior, but there is much more to be learned. Both ablation and stimulation of certain lobes, as well as specific nuclei of the brain, have been performed in man and animal. In both man and monkey, the removal of the temporal lobe produces striking changes, such as fearlessness, docility, and emotional unresponsiveness. These changes are similar to those observed in patients with pyschomotor or temporal lobe seizures. The temporal lobe also influences aggressive behavior and is also the memory lobe. The processing, storage, and recovering of facts and thought necessary for learning and behavior, and the higher cerebral functions are known to occur in the hippocampus and anterior temporal lobe cortex.

Other areas, such as the hypothalamus, modulate, inhibit, and excite behavior which is served by the temporal lobe. Aggressive behavior and passive, withdrawn activities, are partially controlled by the hypothalamus. The reticular formation throughout the brain stem serves to orient, alert, and provide the individual with the ability to react to specific or general, stimuli. In this way, sensory input may be received through the eyes, ears or other receptors and may be appropriately stored and utilized immediately or in the future. These basic structures

and functions must be understood by the physician in order that he may appreciate the varying manifestations of cortical and subcortical structures, which may be injured and result in cerebral dysfunction.

Chronic neurological disorders of a subtle nature may appear when the child is beginning to walk or talk. Such disorders appear frequently between 2 to 4 years with behavior and language problems. Neuromotor disorders may accompany these problems. The peak incidence is between 3 and 10 years of age. With time, the disorders may become less apparent; however, it is important to realize that the age when the child's problem begins should relate to cause and natural history of the disorder. The various ages of the onset are recorded in Table 1.

While children with hyperactive behavior syndromes often have an underlying neurological disorder, these neuromotor, language, or learning disorders may not be detected early. Frequently, however, the behavioral signs are apparent during the neurological examination. The physician must recognize that these underlying neurological disorders may not be striking until the child is older.

INTELLECT LEVELS

Some children with average or bright intelligence (intellectual quotients of 100 to 120) will have marked hyperactivity, impulsiveness, and distractibility. In these children a trial of tranquilizing medication may be of great benefit to the parents and the child.

Most of these children, however, have borderline intelligence. Medication should be considered in an effort to improve behavior and learning, while counseling by teachers and the physician often improves the parents' understanding of the child. In many instances, a social worker can contribute to the overall management of the parents and child, finding appropriate educational, social, and recreational activities.

The neurological examination reveals a few subtle abnormalities while the electroencephalogram may be abnormal with nonspecific slow waves and spike activity in 60 per cent of the electroencephalograms. This does not mean there is an epileptic disorder, but that there has been either a delay in maturation of certain areas of the brain or that there has been injury to the abnormally firing neurons, which result in the abnormal electrical activity. Certainly, in such children, medication, either a major or minor tranquilizer or anticonvulsive medication is worth a trial. Most children will outgrow these problems by 3 to 4 years usually with adjustment to school and community life.

LEARNING FUNCTIONS

There are numerous brain areas related to learning other than the visual, auditory, tactile, and association areas. The most important areas are those related to behavior, attention, storing and retrieval of information, memory. The areas of the brain which serve these functions have been previously reviewed.

The common learning disorders are those of reading (dyslexia), writing (dysgraphia), and arithmetic (dyscalculia). In many children, there are genetic and acquired insults which contribute to the disorder. The child may have reversal or omission of letters or numbers, inability to color within the lines, or have learning problems out of proportion to the social, motor, or language development.

Abnormal motor movements or posturing, such as choreiform movements, poor right-left orientation of limbs, identity of fingers and body parts, and alterations in hand, foot, eye dominance may be present. Incoordination of gait, or awkwardness may also be observed on careful examination. There are obvious visual, motor or perceptual distortions in what the child sees, copies or tries to read. This leads to difficulties in reading, such as reversing letters when writing, mirror writing, reading "pot" for "top," "saw" for "was," and difficulties with words such as "the," "an," "for," "of" and other small words.

These children exhibit behavior described in Table 1. They withdraw, may be shy, hyperactive, and indifferent, but later become poorly motivated because they cannot read and achieve as other children.

READING SKILLS

Obviously, reading as an acquired skill is the key to education today, and the parent-child concern is certainly warranted. Classes for perceptual handicapped children give eye and hand training, and in two or three years they learn to read, or improve, and may continue in regular classes.

Frequently, behavioral or other problems require counseling and medication, such as tranquilizers or anticonvulsants. The prognosis for learning, if the problem is recognized early, is obviously much better than if a child reacts to his problem with obvious delinquent behavior.

Children with a delay in language may have

deafness, aphasia, mental retardation or a psychogenic disorder of language. The observation of the child, his behavior, his production of speech and understanding of the parents, siblings, and peers can be determined by playing and talking with him. In some instances, staring episodes, hyperactive behavior, distractibility and pallor followed by sleep may suggest a psychomotor convulsion in association with the language disorder. The anatomy of language is similar to that of learning and behavior, and thus, a perceptual disorder may also be present.

The phases of development of inner, receptive and expressive language give the child a vocabulary of 250 words by 2 years and 2,500 by 6 years. This can be used as a guide to the child's development of learning, language, and behavior.

Early detection before 3 years is absolutely essential for either deaf or aphasic disorders. Early language training is a must for the child to relate with the world about him.

Medication such as tranquilizers, phenothiazines, and anticonvulsants may improve both behavior and the development of language. The evaluation includes a thorough history and examination, frequently an EEG.

Dyskinesia is faulty motor control such as clumsiness, incoordination and abnormal motor movements observed in children with behavior problems. Often, minimal clumsiness or purposeless, jerky, choreiform movements of the limbs are observed in a child with a learning problem. The child seeks attention and is usually friendly and popular. His short attention span and unpredictable behavior may aggravate the motor abnormality and thus alter his language development, reading and comprehension skills.

DYSFUNCTION CONSEQUENCES

Cerebral dysfunction may result in psychological reactions or psychiatric disorders. If a child has difficulty and is told by teachers, parents, or peers that he is lazy, that he is mentally retarded, that he is different, he is most certain to develop a neurosis. The most frequent problems are seen in children who have a reaction to a learning disability; that is, reading. These individuals experience frustration because they are unable to perform like their peers. Anger, depression, feelings of hopelessness, and poor self-image and motivation may become a part of defeatist attitude which may be present for years.

ENCOURAGE CHILDREN

It is imperative that these children be encouraged and stimulated to continue their education, which must be carried out in a special environment. Only by early detection during the early learning years between 7 and 9, can this most appropriately be done. The need for such careful handling is substantiated by studies which demonstrate the high percentage (50-80 per cent) of reading problems observed in juvenile delinquents.

Everything must be done to prevent neuroses, and proper educational placement must be sought so the child can stay in school.

Frequently, the child who demonstrates cerebral dysfunction and chronic neurological disorders, is one who has failed kindergarten, who daydreams, can't sit still, writes backward, never reads, does not know his right from his left. He has signs of cerebral dysfunction which include right-left disorientation, dyskinesia, or choreiform movements, incoordination, articulation defects, follows commands poorly, deep tendon reflex asymmetry, and mixed cerebral dominance. These recognizable clinical, neurological, and behavioral signs are easily detected and should warn the physician of an underlying problem. Only by early detection can a reasonable solution be devised. ★★★

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Professional Dilemma: Tax Equity Through Corporate Structure?

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Glaring inequities in tax benefits exist between the corporate employee and the self-employed professional individual, many of whom seek parity through the device of the professional practice corporation in preference to the Keogh approach.

Through a decade and a half of litigation in the federal courts and as a target of adverse Internal Revenue Service regulations, the professional corporation remains dependent upon court decision for its being and durability. Its tenuous position as a useful tax shelter and its high potential if based in federal statute remain the central issue in the professional individual's decision in his quest for tax equity.

FOR HALF A CENTURY, since the enactment of the first Internal Revenue laws prescribing an income tax, there have been tax inequities between the self-employed professional individual and the employee of a corporation. Because a corporation is an artificial person with limitation of liabilities and special privileges in commerce, it has logically followed that beneficiaries of corporate employment profit handsomely over the self-employed in taxation.

A corporation may write off in full all payments to or in behalf of any employee, whether delivered or deferred. The corporate owner-employee may depreciate his investment and interests while enjoying profits and concomitant tax advantages.

By sharp contrast, the self-employed professional person may not depreciate his primary capital investment, the staggering cost of his education and the loss of earnings in post-doctoral training. Until recently, he had little or no tax advantage in making conservations for his retirement. And a court judgment can wipe out every nickel he owns and leave him hopelessly in debt.

So while they invest two decades to achieve professional status, the doctor and lawyer have every right to envy the butcher, the baker, and the candle-stick maker, especially when meat, bread, and candles are comfortably incorporated.

Let's look behind the gobbledegook of the tax statutes and see exactly what happens in the land where all men are emphatically not equal before the Commissioner of Internal Revenue. We will follow the fortunes of hypothetical twin brothers, John and James Doe.

John and James were graduated from college, John in premed and Jimmy, in business administration. John entered medical school, earned his M.D., and took a year of internship training. After two years in the military service, he completed a residency in medicine in three more years. So in just 10 years after earning his B.S., he was ready to hang out his shingle and earn his own way.

Jimmy, a resourceful and enterprising soul, landed a dealership for farm machinery, secured a loan from the bank, incorporated his new business, and went to work—the year after college. As with most small businessmen, he paid himself virtually all corporate profits in salary.

As the farm machinery business prospered, he established a qualified corporate retirement program for himself and his employees. The corporation properly and lawfully deducted every dime paid into the retirement program, and with

Executive Secretary, Mississippi State Medical Association.
Adapted from a research study for the Board of Trustees, 1968.

a generous vestment schedule, Jimmy and his employees were soon able to savor their respective and substantial nest eggs. And all the while, Jimmy was enjoying the further tax advantage of depreciating his building, tools, equipment, and every physical property of the corporation.

Dr. John, the internist, wasn't quite as fortunate. While he depreciated his clinic building for tax purposes and enjoyed some small assistance from a law which recognizes that a stethoscope will eventually wear out, he had no way available to write off a cent of his 12 years of education, his primary capital investment.

Until the Keogh Act became law, Dr. John paid taxes as usual on every dollar he set aside for retirement or for his family's security and comfort. He managed to shave off a few dollars here and there from the tax bill with a trust for the children and meticulous estate planning. But he was a young physician, rising toward his professional prime while building his practice. As such, he was not overly burdened with the coin of the realm.

It is hardly surprising that when John and James Doe celebrated their 40th birthday, Jimmy threw the party.

PROFESSIONAL CORPORATIONS

Since the mid-1950's, the professional service or practice corporation has found wide favor among self-employed professional individuals. Under ideal circumstances, such corporations would offer virtually the same tax advantages as conventional, commercial corporations. There have been a series of landmark court cases and a flood of state enactments aimed at achieving a secure corporate status for the self-employed.

Regrettably, these ideal circumstances simply do not exist, and the status of the professional corporation remains a tenuous and complex matter, tipping back and forth between decisions of the federal courts and the mailed fist of the tax collector.

After six years of Keogh, initially a disappointment to many of its supporters, many self-employed professional persons are fully convinced that the corporation is the optimum tax posture for their economic security. Those casting their financial lots in this manner have faced at least a difficult decision. At worst, they have gambled on future court decisions.

The concept of an associated group of professional individuals' endeavoring to clothe themselves with corporate characteristics for tax benefits is not new. A generation ago in 1936, the federal courts ruled in the case of *Pelton v. Commissioner* to uphold the Commissioner of Internal Revenue's contention that an unincorporated group of physicians in Illinois should be treated for federal tax purposes as a corporation. A notable precedent might have been set but for the irony of the entire matter being struck down by the Illinois State Supreme Court which ruled that a corporation could not practice medicine in the state.

KINTNER—RISE AND FALL

In the early 1950's, a Montana physician named Kintner organized his medical group as a "professional association" and claimed corporate characteristics for tax purposes. The Treasury Department immediately took the position that it would tax the group as a partnership rather than as a corporation.

Kintner pressed his cause, and the Treasury Department filed suit to maintain its position. In *U. S. v. Kintner,* a federal district court held that Kintner association might be taxed as a corporation. The Treasury Department appealed, losing its case through the appellate avenues of relief.

But the bombshell came when the Internal Revenue Service announced that it would not honor the Kintner decision. In 1960, IRS countered with its first set of regulations in which the Kintner approach was destroyed.

Under the Internal Revenue Code, the commissioner may issue regulations which need neither further legislation nor court decision to put them into effect. His 1960 regulations, the court decision in favor of Dr. Kintner notwithstanding, said in effect that it was impossible for an unincorporated group of professional individuals to be taxed as a corporation unless they were, in fact, a corporation.

STATE LEGISLATION

Since the court decision conferred a privilege upon an unincorporated group and since the IRS regulations were aimed at these groups and not at corporations *per se,* the Kintner advocates took the only course of action open to them, the route of state legislation. Through Aug. 31, 1967, a total of 34 states enacted some sort of professional corporation statute. This state legislation was aimed at satisfying the requirements of the 1960 IRS regulations.

The Treasury Department and the Internal Revenue Service were not idle, and in 1965, a

second set of regulations were issued "in response to an outpouring of state legislation authorizing the formation of professional service corporations . . . aimed at providing professional men, such as lawyers or doctors, with the means of achieving corporate or association status for federal tax purposes."

The 1965 regulations provide in essence that an organization of professional individuals, incorporated or unincorporated, cannot be taxed as a corporation unless "the corporate characteristics are such that the organization more nearly resembles a corporation than a partnership or a trust."

It is clearly seen that this time, Treasury and IRS were gunning for corporations erected under the various and varying state enactments. It was, in effect, an extension of the 1960 regulations which had been aimed only at unincorporated, Kintner-type groups.

To this point, here is the chronology of events: Kintner secured his right to be taxed as a corporation, although unincorporated, through the courts. The government retaliated with regulations saying that to be taxed as a corporation, you must be a corporation. The professional groups went to their respective state legislatures, securing laws making them lawful corporations while preserving their professional prerogatives and status. The government again responded by saying that whatever your status, you must have corporate characteristics to be taxed as a corporation.

ATTORNEY SUES U.S.

In the past two years, there have been five cases before the federal courts testing the ability of the government to impede professional corporations. Perhaps the most important case aimed at clarifying the tenuous posture of the professional corporation was that filed by a Colorado attorney named Lawrence G. Empy.

Empy was employed by the law firm of Drexler and Wald which, for federal tax purposes, was a corporation under state law doing business as Drexler and Wald Professional Co., Inc. The Treasury Department had applied its 1965 regulations to the firm's situation and found that because of the relationship between lawyer and client, they (the law firm) cannot by organizing or incorporating achieve the status of a corporation for federal tax purposes.

The case was tried as *Empy v. U. S.*, and in reviewing the facts of the case, the federal court summarized the question at litigation by stating that "if taxed as a corporation, plaintiff, who was an employee of Drexler and Wald, prevails. If taxed as a partnership, the claim for refund fails." Drexler and Wald had paid partnership, not corporation, taxes under protest after the adverse Treasury ruling.

COURT UPHOLDS EMPY

The court found for the plaintiff, Empy, holding that Drexler and Wald had the objective of carrying on the practice of law for profit and to divide the gains therefrom; that by its corporate charter, the firm had perpetual life and continuity of life in that the death, insanity, bankruptcy, retirement, resignation, or expulsion of any firm member would not and could not cause dissolution of the corporation; that the officers and directors were vested with lawful authority and had exercised same; that shareholders have liability except for professional liability for which insurance had been purchased; and that the organization more nearly resembles a corporation than a partnership.

The key aspect of the ruling is this: "The Treasury's position that organizations of doctors and lawyers cannot meet the test of corporate resemblances is contrary to the facts as found by the court and is contrary to *Pelton* and *Kintner*. In both cases, the courts found that an unincorporated association of doctors had sufficient corporate characteristics to require their taxation as corporations."

Thus, the federal courts have lashed back at both sets of Treasury and IRS regulations. Moreover, no state law permitting professional individuals to incorporate has yet been questioned as to constitutional validity.

There is another highly significant finding in the Empy decision, one which might escape even the serious student of this complex issue. The court also recognized professional liability as may be incurred by professional individuals within the professional corporation framework. The decision stated in part:

LIABILITY CLARIFIED

"Shareholders are liable for corporate debts except during periods of time when the corporation shall maintain lawyers' professional liability insurance in specified amounts; the court finds

that Drexler and Wald has at all times carried such insurance in the specified amounts and that the nature of the liability of the shareholder of Drexler and Wald is more similar to that of a corporate shareholder than to that of a partner."

This part of the decision is especially devastating to those who have argued, in opposition to the professional corporation, that liability resulting from malpractice of a professional may never be assumed by a corporation.

The Empy case and at least one other are on appeal to the United States Supreme Court. *Pelton* and *Kintner* appear as supporting precedents, and there is still another which may be helpful. In *Galt v. U. S.,* the federal court held that a Texas medical group, although unincorporated, could be taxed as a corporation. The importance of this case lies in the fact that Texas law forbids a corporation to practice medicine.

Does all this mean that the issue has been resolved, especially if eventually upheld by the United States Supreme Court? Unfortunately, it does not, because the taxing power of the government is broad and flexible. Treasury can almost make law with its regulatory powers. To this moment, the ideal circumstances enjoyed by the conventional, commercial corporation simply do not exist for the professional individual.

MSMA POLICY POSITION

Since the first Kintner decision, a number of bills have been before the Mississippi Legislature proposing authority for formation of professional corporations. The attorneys of the state, as a group, have been avid supporters of Keogh, while the physicians, caught up in compulsory federal medical care under Social Security, found a more compelling reason for opposition.

At the 94th Annual Session in 1962, the House of Delegates considered the issue of professional practice corporations. The House pointed to the association's support of voluntary retirement plans for the self-employed under tax deferment. At the time, any move to endorse professional practice corporations would have also constituted endorsement for mandatory inclusion of physicians under Title II of the Social Security Act, something then almost universally opposed in medicine.

When Senate Bill 2190 was introduced before the 1968 Regular Session of the Mississippi Legislature, it was noted that the measure was not especially remarkable in that it was a minimal enabling act for professional practice corporations.

It was the child of the insurance and annuity interests, not of the major professional groups. The state bar association acted to exclude attorneys from its provisions. With no basis for supporting the measure, the state medical association took no position on the legislation in deference to those physicians who feel that corporate status would be of benefit to them. The Legislature passed the measure, excluding both attorneys and physicians.

MISIMPRESSIONS OVER KEOGH

Some few physicians have misunderstood the enactment, believing it related to Keogh, which it is not. As with the enactments of other states, Senate Bill 2190 offers no guarantee of a lasting or durable tax shelter in the professional corporation. This depends not upon state law but upon federal law.

Still other physicians may not clearly understand that when a doctor of medicine becomes associated in a professional corporation, he immediately forfeits his eligibility under Keogh.

These are the pro's and con's of the controversial professional practice corporation and the even less secure unincorporated professional association which claims corporate characteristics. To this moment, the security and being of the professional corporation as a beneficial tax device is wholly dependent upon the vagaries of litigation and the decisions of the federal courts.

The whole issue, being up and down, in and out, is still very much unresolved.

There is a way, safe and certain, to secure lasting durability of the professional corporation and to interdict and foreclose the possibility of further effective opposition from the Treasury Department and the Internal Revenue Service.

If, and this conditional circumstance is emphasized, the professional corporation concept, applying equally to incorporated and unincorporated professional groups, is formalized into federal tax law by amendment of the Internal Revenue Code of 1954 and if the amendment is sustained in the federal courts, there can be no question that it would be superior to Keogh as the latter is presently constituted.

FOR MANY—NO GOOD

There is, in all candor, a qualification here, because for many physicians, the device of a corporation will be unwieldy and expensive. The presently liberalized Keogh Act, allowing tax deferment of $2,500 off the top of the before-

taxes net, is for them a better deal. For others, especially groups, the corporation is superior.

This much is now certain: Keogh, however inadequate, is *fait accompli;* the professional corporation as regards a basis in law is not. And it is not unreasonable to assume that litigation over the professional corporation will continue in one form or another, especially by the Treasury Department. The choice now among self-employed professional individuals is to decide where their fortunes lie and just how good their advice influencing their respective decisions really is along with the interests of those who offer it.

In the meanwhile, there is only one durable and certain way to clean up and stabilize the professional corporation, and that is for the Congress to decide the matter once and for all. ★★★

735 Riverside Drive (39216)

REFERENCES

1. *Pelton v. Commissioner, (C.A. 7th) 82 F. 2d 473 (1936).*
2. *U. S. v. Kintner, 216 F. 2d 418 (C.A. 9th) (1954).*
3. Rev. Rul. 56-23, 1956-1; Cum. Bull. 598; Ref. Sec. 7701, Int. Rev. Code 1954.
4. *Galt v. U. S., 175 F. Supp. 360 (N.D. Texas, 1959).*
5. *Empy v. U. S. (66 C 373, U.S. Dist. Ct. Colo.) (Aug. 31, 1967).*
6. Suppl. Rpt. B, Board of Trustees, and action of the House of Delegates, Transactions of the 94th Annual Session, Jackson, Miss. State Med. Assn., 1962.

WASHINGTON WONDERLAND

Rep. Craig Hosmer (R., Calif.) is one congressman with an oversize funny bone. Here are some of his observations on the Washington political scene: The first year in the Congress, you wonder how you got there. The next year you wonder how the rest of the members got there. . . . A senator was re-elected for a six year term and feeling himself secure, he sent the following telegram to a complaining constituent: "Go soak your head in a barrel; strong letter follows." . . . The trouble with some political jokes is that they sometimes get elected to office.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, July 13-17, 1969, New York, N.Y.; Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo. E. B. Howard, Acting Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.



The President Speaking

'Positive With Prevention'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE SPLENDID RECORD being written by component medical societies, hospital staff groups, and our several medical communities in immunization programs demonstrates the concern of the medical profession in preventive care. On two occasions, the House of Delegates of the state medical association has acted affirmatively to encourage sponsorship of immunization campaigns under the aegis of medical organization in Mississippi.

It has been waggishly said that anyone who takes advantage of all the advances of immunology would resemble a pincushion. But weighed seriously against the consequences, the small effort incurred on the part of patients is eminently worthwhile.

Component societies and local medical groups responded encouragingly to the call of the 100th Annual Session for positive action to protect the public against tetanus. Immunization campaigns were conducted from Corinth to the Gulf Coast. More recently, campaigns offering the measles vaccine have been in the news, as the profession is doing its part to put this disease on the shelf with the conquered killers of yesteryear.

It is in this type of public service that medicine communicates its message with sincerity and effectiveness, because there are few enough business and professional persons in the world today trying to work themselves out of a job. Moreover, this positive program requires little expenditure of time in comparison with more extensive programs which may not be as effective, either as measures of health protection or communications value. Let's be positive with prevention in 1969. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME X, NUMBER 1

January 1969

EDITORIALS

Tempest in the Memphis Hospitals: A Call for Statesmanship

I

THERE IS A TEMPEST at the moment about out-of-state charity patients in Memphis, and Mayor Henry Loeb and his hospital officials have taken decisive action to put down the controversy. Mr. Loeb and spokesmen for the city's complex of five major hospitals, Warren B. Cruzen, vice chairman of the board, and Odell Horton, director of hospitals and health services, imposed a Dec. 15 deadline cutting off all but emergency admissions for Arkansas indigents. They are negotiating with Mississippi.

Memphis officials say that the city is sustaining losses of about $200,000 annually on patients from nearby Crittenden County across the river and about $500,000 on patients from north Mississippi. The city reports expenditure of $1.9 million annually on all charity care in the five hospitals.

Although care of those from Arkansas involves considerably lesser amounts of money than does the care of Mississippians, the running debates have waxed hottest with the state house at Little Rock. Governor Winthrop Rockefeller, in lengthy exchanges with Memphis city officials, agreed to pay for all care rendered Arkansans except obstetrics. The city promptly rejected this offer, responding that obstetrical care was the biggest item for indigent patients west of the river. A cutoff ultimatum has yet to be issued to Mississippi, but the matter is now in the Governor's office.

II

For many years, some indigent patients from north Mississippi have been readily admitted to the hospitals in Memphis. And while it is not widely known, the State Hospital Commission has regularly paid the hospitals the statutory maximum for care of these patients. Every physician in Mississippi knows that Memphis hospitals are second only to the New Orleans institutions in training programs which generate almost insatiable need for teaching patients.

But as the financial pinch was inevitably felt, Mayor Loeb wrote Governor Williams and according to press reports, threatened to cut off admissions from Mississippi unless compensation arrangements more to the liking of Memphis were made. Governor Williams has pointed out that current payment levels to Memphis hospitals represent the maximum authorized by the Legislature. He said that he would bring the matter to the attention of the next Regular Session in 1970. Previously, state officials have asked the Memphis authorities to talk to county officials in north Mississippi, but Mayor Loeb has rejected this proposal.

As the State Hospital Commission program

goes, and it is admittedly outdated and inadequate, the state hasn't been stingy in meeting its obligations in Memphis. From January through October of 1968, the state paid Memphis more than $126,000 for care of these patients. The governor has said that he recognizes that a reimbursement of $12.50 per day is insufficient, but he said with equal candor that the present budgetary limitation runs until June 30, 1970, and that only the Legislature can do anything about it.

III

If this were a squabble over home-and-home games for Ole Miss which have been known to drop a few Mississippi dollars into the Memphis economy or the hefty volume of wholesale and retail business done by Memphis business firms in north Mississippi, perhaps it could be handled a little differently. This is obviously a serious matter with well-being in health and life at stake.

Moreover, the state of Mississippi has shown no bad faith in this matter, meeting its obligations here at the top of the statutory limit set by the Legislature. Our governor, with promptness and candor, has promised to do all that he can in bringing this matter before the Legislature.

It is not irrelevant to recall that the Regional Medical Program for west Tennessee, centered in Memphis, claims a good bit of north Mississippi as its territory. On the basis of this claim, the Memphis-based RMP is receiving federal funds. It is also notable that there exists a close link between the practicing physicians in Mississippi's northern environs and the profession in Memphis. The constant flow of referrals reflects the confidence, esteem, and respect in which the medical community in Memphis is properly held by Mississippians, physicians and patients alike.

These fraternal, commercial, and professional ties make the old saw that the Mississippi Delta begins in the lobby of the Peabody more of a factual assertion than a joke. With equal basis in fact, there are thousands of Mississippians who literally don't believe anything until they read it in the *Commercial Appeal.*

IV

This friendly, candid, and objective examination of a serious matter isn't intended as a defense of a private and unofficial Title XIX program where Memphis puts up the difference. Indeed, the governor of Mississippi has made that quite clear. This is to say that there is much more involved in the care of these patients than the imposition of a deadline on admissions pending a settlement of growing disparity in financing.

The city of Memphis makes a mighty contribution to the South. Because of its unique geographic and cultural situation, Arkansas and Mississippi also make contributions to Memphis. To this extent, many common fortunes rise and prosper, not merely on this good relationship but on its stability, elements of mutuality, and growth.

Let it be sincerely hoped that the present difficulties may be met effectively with resolve and a lasting solution. There are good men in Memphis and Mississippi with equally good intentions and equal dedication. Give them time to exercise statesmanship.—R.B.K.

Minimum Wage and Hospital Charges

The second round of minimum wage increases becomes operative Feb. 1, affecting, among others, employees of hospitals and nursing homes. The 1969 escalation pegs the minimum wage at $1.30 per hour, up 15 cents over the current floor.

The law also provides that employees will be entitled to overtime pay at time-and-a-half rate for work in excess of 40 hours in one week. An exception may be made in the case of certain hospital employees with agreements to work fixed periods of 14 consecutive days. Their overtime compensation rates is fixed for periods in excess of eight hours in one day or 80 hours in the 14-day period.

The Feb. 1 step increase, slightly over 13 per cent, will inevitably show up on the patient's hospital bill. The first wage floor made mandatory by the 1966 amendments to the Fair Labor Standards Act was said to have upped hospital *per diem* costs by as much as $6 in some Mississippi hospitals.

There is, for the moment, a tempering influence, according to some hospital spokesmen. Upward adjustments in daily rates for rooms and various services have anticipated the approaching wage step. While many hospitals may make further adjustments in charges, others will not. Where possible, the price line must be contained by seeking new economies without sacrifice of care quality. Insurance, prepayment, and budgeted appropriations or government programs are strained as it is.

By instituting peer review of usual and customary charges, physicians are doing their part to

assure that fair practices prevail in the medical service cost picture. Hospitals can do no less.—R.B.K.

Mary Mallon, Forgotten Figure of History

A century ago last month, Mary Mallon was born, and 30 years ago to the month, she died at age 70. Except to a few students of medical history, her surname was simply never known, but she lives in the annals of the literature by, of all things, a nickname as familiar to physicians as the names of Lister, Pasteur, Halstead, and Banting.

Mary Mallon, an unremarkable and unfamiliar person, was none other than the famous "Typhoid Mary" of the early 1900's.

Mary's fame is owed to a sanitarian who worked for the New York Department of Public Health, one George A. Soper. Assigned to study outbreaks of typhoid fever in suburban New York homes, Soper found that water and food supplies were beyond suspicion. Had he been a less alert man, he could have concluded his investigations as an engineer and called in the epidemiologists.

Soper, in a diligent and imaginative manner, looked beyond his duties as a sanitarian and discovered that a domestic, one Mary Mallon, had worked as a cook in the households of a number of the afflicted families. Interestingly enough, the typhoid outbreak always followed but never preceded her employment. Examination of her feces confirmed that she was a chronic typhoid carrier.

Mary must have sensed this before the diagnosis was made, because when typhoid appeared in a family she served, she made it an unvarying practice to leave at once without giving a forwarding address. Mary was an ill wind who blew some good, for it was she who was largely responsible for instituting the public health practice of seeking a carrier among those in intimate association with or who prepared food for typhoid patients. As with 20 per cent of all such carriers, Mary never suffered from any illness diagnosed as typhoid fever.

The Mallon name also turns up in the legal literature or case law, too. Between 1907 and 1910, while detained by New York public health officials, Mary sought her release through the courts. It was really here that her fame—and her uncomplimentary nickname—grew and became household words. The New York State Supreme Court upheld the right and duty of the public health department to keep her in involuntary isolation. It was not a landmark decision, however, because the right of the community to isolate those with chronic contagious disease, notably tuberculosis, had already been firmly established.

In 1910, Mary was released from confinement, and following her old habit patterns, she promptly disappeared. In the next two years, typhoid fever turned up in a New Jersey and a New York hospital, affecting 200 individuals. Sure enough, Mary had returned to her old occupation, hiring in as a cook at each hospital. This incident was not without profit to the scientific community, because it taught the public health authorities once and for all that a carrier must always be followed carefully and never allowed to handle the food and drink of others.

Dr. Julia L. Freitag, director of the Bureau of Epidemiology of the New York Health Department, reports that there are only 170 registered typhoid carriers in that state today. Many former ones have been cured by cholecystectomy or by responding to treatment with certain antibiotics. In Mississippi, there are currently 102 carriers by known address, and each is carefully followed by the State Board of Health and the appropriate county health departments.

Unhappy Mary Mallon had the ill fortune to bring a dread illness to hundreds, but in becoming the focus of national attention, she made a mark in public health education and the formulation of policies which spared thousands in prevention.—R.B.K.

From Washington to Ann Arbor—Not Retirement

Within the month, HEW Secretary Wilbur J. Cohen steps down from his high post in the Johnson administration to return to his academic home, the University of Michigan. But this does not mean that he has also removed himself from a policy-making role in government health care, for it was from his university post that he authored the Social Security Act.

Brought into public life by the late President John F. Kennedy, Professor Cohen rose to the secretariat of HEW when John Gardner resigned. His acquaintance with President Johnson dates back many years when he was the unofficial adviser to the Congress on amendments to Social Security.

Professor Cohen is generally acknowledged as

the author of the Kerr-Mills Act in 1960, and he wrote drafts of the Forand and King-Anderson bills. While Public Law 89-97, Medicare, containing both Titles XVIII and XIX, was written during a five months executive session of the House Committee on Ways and Means in 1965, it would come as no surprise to have confirmation that Cohen was consulted by the committee.

In a pre-Christmas letter to the tens of thousands of HEW employees, Secretary Cohen outlined 13 health goals for the 1970's. Some are noncontroversial, and he carefully avoided details on how to get the controversial ones implemented. His goals are:

—Continued expansion of medical research and more rapid dissemination of new knowledge to prevent and cure illness.

—Elimination of economic barriers to medical care, through comprehensive health insurance and other public and private programs.

—Major reduction in infant mortality and early childhood disease.

—Elimination of malnutrition.

—Improvement in the organization and delivery of medical care with continued emphasis on high quality.

—Widespread transplantation of human organs and development of artificial organs.

—Expanded prevention and improved chances of recovery from heart disease, stroke, and cancer.

—Increase of health manpower and better use of professional skills.

—Elimination of large mental institutions and expansion of community mental health centers accessible to all.

—Family planning services available to everyone.

—Improvement in the quality of the environment, with major reduction in air and water pollution.

—Reduction of alcoholism, drug addiction, mental illness, mental retardation, and accidents.

—Elimination of smallpox, diphtheria, polio, whopping cough, and measles.

It's a safe bet that Professor Cohen will be a star witness at any future hearing on any amendment to the Social Security Act. It is just as safe to bet that he will be in the forefront defending the welfare system if the new Nixon administration proposes cutbacks of any significance. In a nutshell, Professor Cohen really isn't retiring—he's just moving.—R.B.K.

Test Yourself on Your Health Insurance

Many individuals are inclined to be casual or even indifferent about important things in their lives, and the insurance they own is no exception. Try this out on yourself:

—What insurance company issued my automobile insurance?

—What are the co-insurance provisions on my home?

—What are the anniversary dates of my life insurance policies?

If you answered one of the three questions correctly, you are exceptional—or in the insurance business.

Health insurance and prepayment has become a household necessity, and too few really understand what coverages they possess and which ones they do not. In fact, physicians usually find themselves explaining the terms of an insurance contract to a patient, especially when the coverage is limited.

The Health Insurance Institute says that there are seven key questions to ask about your medical and hospital coverage in making an assessment of how it measures up to today's need.

—Which members of my family are covered?

—What are the maximum benefit limits in terms of amount and length of time?

—How do these benefits compare with the level of health care costs in my community?

—What waiting periods, exclusions, and limitations are in my contract?

—What deductibles and percentage of co-insurance are involved?

—Who has the right of renewal of my health insurance coverage, and is it guaranteed renewable at my option?

—What hospital and medical services are covered under the provisions of my contract?

To these questions, you might add: Where is the contract and identification card right now?

—R.B.K.



To assure presentation of complete biographical data on newly elected members, especially those elected during December 1968, and because none was reported during November, this department has been deferred for the present issue.

POSTGRADUATE CALENDAR

COMMON SKIN DISEASES

University Medical Center, Jackson
January 24, 1969, beginning at 9:30 a.m.

Sponsored by the University of Mississippi School of Medicine Postgraduate Education Committee and the Division of Dermatology, Department of Medicine

Participants:

John A. Brown, M.D., clinical instructor in medicine (dermatology), University Medical Center

John Busey, M.D., clinical professor of medicine, University Medical Center, and chief of medicine, Veterans Administration Hospital

Charles Caccamise, M.D., clinical assistant professor of medicine (dermatology), University Medical Center

John G. Forshner, M.D., clinical instructor in medicine (dermatology), University Medical Center

John F. Jackson, M.D., professor of preventive medicine and associate professor of medicine, University Medical Center

James G. Thompson, M.D., clinical associate professor of medicine, chief, division of dermatology, and seminar coordinator, University Medical Center

Louis J. Wise, M.D., clinical assistant professor of medicine (dermatology), University Medical Center

Friday Morning

Those Confusing Papulo Squames
Dr. Caccamise
Superficial Fungi
Dr. Brown
Phototoxic Eruptions
Dr. Forshner
Acne Vulgaris
Dr. Wise
Warts and Benign Tumors
Dr. Thompson

Friday Afternoon

Inheritance Patterns in Genodermatoses
Dr. Jackson
Contact Dermatitis
Dr. Forshner
North American Blastomycosis
Dr. Busey
Sweat Glands and Sweating
Dr. Thompson
Pyoderma
Dr. Brown
Occupational Dermatoses
Dr. Wise
Atopic Dermatitis
Dr. Caccamise
Discussion of Problem Cases

CIRCUIT COURSES

Physicians in the Hattiesburg and Biloxi areas will host three postgraduate education circuit courses in January. Overall topics for the three sessions in both cities are headache, cancer of the cervix and the diagnosis of cardiac disease. Biloxi's programs will be held at Howard Memorial Hospital at 6:30 p.m. on January 8, 15, and 22. In Hattiesburg, sessions will be offered at Methodist Hospital at 6:30 p.m. on January 9, 16, and 23.

Eastern Circuit

Columbus—Session 1—January 28
Aubrey and Ellon's Restaurant, 6:30 p.m.
Modern Practices in the Management of Tuberculosis
Medical Approach, Dr. Guy Campbell
Surgical Considerations, Dr. Hans-Karl Stauss

Southwestern Circuit

Natchez—Session 2—February 18
Jefferson Davis Memorial Hospital, 7:00 p.m.
Renal Transplantation
Dr. John Bower
Dr. Hilary Timmis

FUTURE CALENDAR

January 13-17
Strokes and Related Neurological Diseases

January 24
Dermatology Seminar

January 28
Circuit Course, Columbus

February 18
Circuit Course, Natchez

February 19
Symposium on Human Sexual Behavior

February 25
Circuit Course, Columbus

POSTGRADUATE / Continued

March 4

CIRCUIT COURSE, MERIDIAN

March 7

KIDNEY SEMINAR

March 17-21

STROKES AND RELATED NEUROLOGICAL DISEASES

March 26-28

CARDIOVASCULAR SEMINAR

April 1

CIRCUIT COURSE, MERIDIAN

April 15

CIRCUIT COURSE, NATCHEZ

April 22

CIRCUIT COURSE, COLUMBUS

May 6

CIRCUIT COURSE, MERIDIAN

May 12-15

MISSISSIPPI STATE MEDICAL ASSOCIATION



PERSONALS

A. V. BEACHAM of Magnolia was honored by Gov. John Bell Williams who paid tribute to the physician-administrator upon retirement as director of the Alcohol Beverage Control Division. The governor characterized Dr. Beacham's administration as "one of honesty and free of any scandal."

JAMES E. CALLOWAY, JR., of Louisville has announced the removal of his offices to 313 N. Court Ave.

ANDREW J. CARROLL, JR., and T. ERSKINE ROSS, JR., of Hattiesburg were honored for 20 years of uncompensated service to Local Board 20 of the Selective Service System as medical advisers. Each received a Presidential Citation and special lapel pins presented in recent ceremonies by Col. S. H. Weeks of Jackson.

ROBERT E. CARTER and HUGH B. COTTRELL of Jackson have been named associate state chairmen of the 1969 March of Dimes campaign in Mississippi. Appointed chairman for the drive is Owen Cooper of Yazoo City. Dr. Carter is dean and director of the University Medical Center, and Dr. Cottrell is State Health Officer.

WILFRED Q. COLE and LOUIS A. FARBER of Jackson have been elected to the nine-member board of directors of the River Hills Club, a major tennis-oriented country club in north Jackson. Dr. Cole limits his practice to pediatric allergy, and Dr. Farber, to orthopaedic surgery.

MARION L. DODSON of Waveland has been elected chief of staff for 1969 at the Hancock General Hospital, Bay St. Louis. Serving with him are CHARLES J. COX of Bay St. Louis, vice chief of staff, and JOHNNY B. LEVENS of Waveland, secretary-treasurer. Dr. Dodson succeeds WESLEY L. MCFARLAND of Bay St. Louis.

C. MIMS EDWARDS of Vicksburg has announced the opening of his offices at the Messina Clinic, 1411 Cherry St., where he will limit his practice to psychiatry.

HARRY C. FRYE of Magnolia has been installed as president of the area chamber of commerce for 1969. He is joined in chamber leadership with two physician-directors on the board, A. V. BEACHAM and WARREN A. HIATT, both of Magnolia.

RICHARD T. FURR of Ocean Springs has appeared as a featured member of the melodrama cast in "Pure as the Driven Snow," presented by St. John's Episcopal Church.

H. LAMAR GILLESPIE of Hattiesburg has been inaugurated as president of the University of Southern Mississippi Alumni Association. Among other officers is JOHN A. MCLEOD of Hattiesburg, Southern district committeeman. The elections were conducted at the annual meeting of the USM alumni association during homecoming.

EARL W. GREEN of Hattiesburg has been appointed to the board of trustees of William Carey College. Previously serving as a member, Dr. Green returns to the board after a year of absence.

MARVIN V. HARVEY has announced the removal of his offices from McComb to North Cherry St. at Magnolia.

JACK L. HERRING has announced his affiliation with the Magee Medical and Surgical Clinic. He was formerly at the Mississippi State Sanatorium for 10 years, occupying the post of assistant superintendent. A native of Raymond, Dr. Herring was with the U. S. Public Health Service prior to coming to the sanatorium.

SAMUEL B. JOHNSON of Jackson appeared as a principal speaker at the recent annual meeting of the Mississippi Society for the Prevention of

When the pink pill for U.R.I. symptoms speeds into action, someone somewhere breathes easier.

You provide prompt and continuous relief from symptoms of U.R.I. when you prescribe Novahistine Singlet. Novahistine Singlet is formulated to quickly relieve the fever and the aches and pains that so frequently accompany upper respiratory infections. And these continuous-release tablets provide a vasoconstrictor-antihistamine formulation to shrink swollen membranes and reduce congestion of the turbinates and sinuses.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

Blindness. He is secretary of the Mississippi EENT Association.

PATRICK H. LEHAN of Jackson has been named the Mississippi Heart Association Love Memorial Research Professor at the University Medical Center. The chair was endowed in 1962 by the state heart association and was renamed last year in memory of the first occupant, the late WILLIAM D. LOVE. A graduate of Georgetown University School of Medicine, Dr. Lehan has held faculty posts at Seton Hall College of Medicine and the New Jersey College of Medicine. He is a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians and a Fellow of the American College of Cardiology.

LAWRENCE W. LONG of Jackson was elected treasurer of the International College of Surgeons at the recent Tokyo meeting. Active in the United States Section of the College, he has served on the Board of Trustees and as chairman of the Finance Committee. He is a past president of the state medical association and currently chairman of the Committee on Publications.

THOMAS E. MAGEE has announced the opening of his offices at Arcola, relocating there from his former city of practice, Vicksburg.

A. N. MORPHY of Gulfport has informed the Harrison County Board of Supervisors of his intention to resign as director of the county health department. Board President Laz Quave publicly expressed the hope that Dr. Morphy would accept another year of extension beyond the retirement age and continue in his post.

ROBERT L. PEEDE of Brandon has announced the removal of his offices to the Brandon Post Office Annex on College St. He was formerly at the Brandon Clinic.

RUDYARD B. ROBINSON of Saltillo has been appointed the Mississippi member of the Appalachia Health Advisory Committee by Gov. John Bell Williams. The governor is expected to appoint a 20 member state advisory committee representing providers of health services and consumers over which Dr. Robinson will preside.

WALTER H. ROSE of Indianola appeared as guest speaker during recent ground-breaking ceremonies as construction was begun on the Washington County Hospital at Hollandale. The new facility will initially have 29 beds.

HANS K. STAUSS of Jackson has recently returned from his first visit to his native Germany after 34 years. He first came to the United States in 1934 to visit his great uncle at Port Gibson. He attended Chamberlain-Hunt Academy, the University of Mississippi, and received his medical training at Washington University at St. Louis. He limits his practice to thoracic surgery.

ELBERT A. WHITE, III, of Corinth has been elected vice president of the Kiwanis Club. Projects of the civic organization this year included fund raising which benefitted the YMCA with a gift of $1,000. Another $1,000 was given by the club for the purchase of downtown Christmas lighting.

DEATHS

GRIMM, JAY JOHN, McComb. M.D., McGill University, Montreal, Canada, 1930; retired from active practice fifteen years ago; died Nov. 16, 1968, aged 79.

HARRIS, WILLIAM ROBIN, Jackson. M.D., Vanderbilt University, Nashville, Tenn., 1911; post graduate work at Willard Parker Hospital, New York City, Sept. 1911-March 1912; St. Johns Riverside Hospital, Yonkers, New York, March 1912-Sept. 1914; EENT Hospital, New Orleans, La., Sept. 1919-Jan. 1921; Vienna, 1928; certified by the American Board of Otolaryngology, 1925; died October 29, 1968, aged 80.

MOORE, DANIEL H., SR., Meridian. M.D., Tulane University School of Medicine, New Orleans, La., 1932; fellowship in EENT, Tulane University 1936-37; died Dec. 14, 1968, aged 62.

WILKINS, E. LEROY, Clarksdale. M.D., University of Tennessee College of Medicine, Memphis, 1911; interned Hosmer Hospital, Dyersburg, Tenn., one year; Chicago EENT Hospital, Oct.-Dec. 1913; member MSMA Fifty Year Club; president Clarksdale & Six Counties Medical Society, 1953-1956; president MSMA, 1943-44; former chairman of the Council on Medical Education, the Judicial Council, and the Council on Constitution and By-Laws; served as an Army medical officer in World War I in France; past president, Clarksdale Rotary Club, and past commander, Clarksdale Post 28, The American Legion; past Grand Chef de Gare, 40 et 8; past chairman, Child Welfare Commission, The American Legion of Mississippi; certified by the American Board of Otolaryngology, 1941; died, Dec. 12, 1968, aged 79.

UMC, VA Join in Nationwide Five Year Coronary Drug Research Study

Physicians of the 500-bed Veterans Administration Hospital at Jackson and the University Medical Center's department of medicine have teamed with 54 other major medical institutions in a nationwide coronary drug research project.

Dr. R. G. Hutchinson of the UMC department of medicine said that the massive research undertaking is a five-year, double-blind study to determine the ability of several lipid lowering drugs to prevent recurrent myocardial infarctions in patients with well-documented previous episodes and to improve longevity.

Drugs under study include conjugated equine estrogens, nicotinic acid, d-thyroxine, and clofibrate.

Dr. Hutchinson said that it is anticipated that between 6,000 and 8,000 patients will be enrolled in the study by June 30. The UMC-VA team hopes to reach a total of 100 enrollees by that time. Eligible patients must be male between the ages of 30 and 64 years of age with well-documented histories of previous myocardial infarction episodes. They must be classified as Functional Class I or II under New York Heart Association criteria and have no other debilitating disease.



Dr. J. D. Morgan, UMC resident in medicine, left, discusses the coronary drug research project with patient-enrollee James Burwell, center, as Dr. Wilford J. Patterson, UMC intern, assists.

Diabetics requiring insulin and patients receiving anticoagulant therapy are not eligible. Dr. Hutchinson said that anticoagulant therapy may be instituted following an acute medical event where a patient has already been enrolled without having to eliminate him from the study participant group. He said that the same rule applies to diabetics found to require insulin after enrollment.

Patients enrolled will continue under the care of their personal physicians, Dr. Hutchinson said, and will be seen at Jackson only in connection with the research. Any new abnormal findings in a patient will promptly be reported to his personal physician.

Patients enrolled in the project are divided at random into a control group and several different treatment groups, one for each of the drugs under investigation. For the first six months, enrollees are seen monthly and thereafter at four month intervals through the remainder of the five years.

All enrollees receive laboratory studies of serum triglycerides, cholesterol, uric acid, plasma glucose, and hemoglobin and hematocrit determinations.

The announcement invited referrals from practicing physicians within 100 miles of Jackson for interviews and enrollment. Referring physicians are asked to communicate with Mrs. Jane Johnson, Heart Project Secretary, Heart Station, UMC, Jackson.

ORGANIZATION / Continued

Singing River Elects 1969 Officers

Members of the newly-chartered Singing River Medical Society have named officers for the 1969 year, according to Dr. Karl B. Horn of Pascagoula, president. The president-elect is Dr. Glyde H. Gunn, Jr., of Pascagoula.

Named secretary is Dr. Donald E. Dore, Jr., and Dr. Paul H. Moore will serve as treasurer. Forming the society's executive committee with the officers are Drs. H. H. Robinson and William J. Weatherford.

The board of censors consists of Drs. J. T. Thompson, Robert L. Thompson, and E. M. Baumhauer. Dr. Dewey H. Lane, Jr., is delegate to the state medical association, and Dr. William B. Winstead is alternate delegate.

Except for Dr. J. T. Thompson and Dr. Gunn who are from Moss Point, all officials of the society reside at Pascagoula.

Trustees Name Advisers for CHP Study

A seven-member advisory committee to the staff task force making a major study for the state of Mississippi was named by the Board of Trustees at its first winter meeting last month. The advisory body represents both association leadership and the seven sections of the Scientific Assembly.

Heading the committee as chairman and representative of general practice is Dr. C. D. Taylor, Jr., of Pass Christian. He is also chairman of the Board of Trustees.

Dr. Joseph B. Rogers of Oxford, association president, is representing ophthalmology and otolaryngology, and Dr. James L. Royals of Jackson, MSMA president-elect, is the committee member representing obstetrics and gynecology.

Immediate Past President Temple Ainsworth of Jackson represents surgery, and Dr. G. Swink Hicks of Natchez was appointed to represent



Dr. Karl Horn of Pascagoula, president of the newly organized Singing River Medical Society, accepts the charter from Dr. Joseph B. Rogers of Oxford, state association president, during ceremonies at Biloxi. Assisting in the presentation was Dr. C. D. Taylor, Jr., of Pass Christian, left, chairman of the MSMA Board of Trustees. Host for the occasion was Dr. Wallace S. Sekul of Biloxi, right, president of the Coast Counties Medical Society.

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preventive medicine by reason of his membership on the State Board of Health.

Completing the group are Drs. Howard H. Nichols of Jackson, pediatrics, and G. Spencer Barnes of Columbus, medicine. Dr. Nichols has been serving as Title XIX chairman for the American Academy of Pediatrics in Mississippi, while Dr. Barnes is a former chairman of the association's Section on Medicine, a leader of the Prairie Medical Society, and a member of the House of Delegates.

The study being made by the association is on information systems for Comprehensive Health Planning under a contract with the Office of the Governor. The association will report to the governor through the director of Comprehensive Health Planning, Dr. Alton B. Cobb of Jackson.

In its first meeting, the advisory committee reviewed early findings of the study task force, heard results of a screening survey to determine existence of information systems being maintained now, and agreed to guides on appointing consultants for final evaluation of systems to be examined in detail.

The advisory committee chairman, Dr. Taylor, said that the study report would be made available to the House of Delegates. It is a major prerequisite to full implementation of Title XIX and will be utilized by the Division of Comprehensive Health Planning in the Office of the Governor.

Scientific Exhibits Are Invited for 101st

Applications for scientific exhibit space at the 101st Annual Session of the association have been invited by the Council on Scientific Assembly. Spokesmen for the council said that final selection of exhibits to be presented at the May 12-15 meeting will be made by mid-February.

The scientific exhibit is open to members of the association, out-of-state physicians affiliated with recognized medical institutions, medical schools, voluntary health agencies, and health-oriented agencies of government.

Applications may be in letter form addressed to the Council on Scientific Assembly. The application should specify the minimum space in linear feet required as well as special requirements such as tables, electrical services, and the like. The association provides draped booths at no charge to the exhibitor.

Council spokesmen said that each application will be reviewed, and a reply will be made to applicants. The letter should also contain the title of the exhibit and the name or names of authors. A listing of exhibits will be published in the April issue of the JOURNAL and in the hand program of the annual session. An announcement of awards to be made for exhibits judged best will be published in April.

Blue Plan Goes Usual, Customary for FEP

Installation of a usual, customary and reasonable fee program for federal employees and their dependents covered under the Blue Shield high option federal employee medical and surgical plan has been announced by Dr. J. C. Woosley, president of the Mississippi Hospital and Medical Service, Inc., as a result of action taken by the plan's executive committee.

The program, effective Jan. 1 will include services such as surgery, in-hospital medical care, anesthesiology, consultation, radiation therapy, emergency first-aid treatment within 72 hours of an accidental injury, and diagnostic x-ray and laboratory procedures in a physician's office or elsewhere.

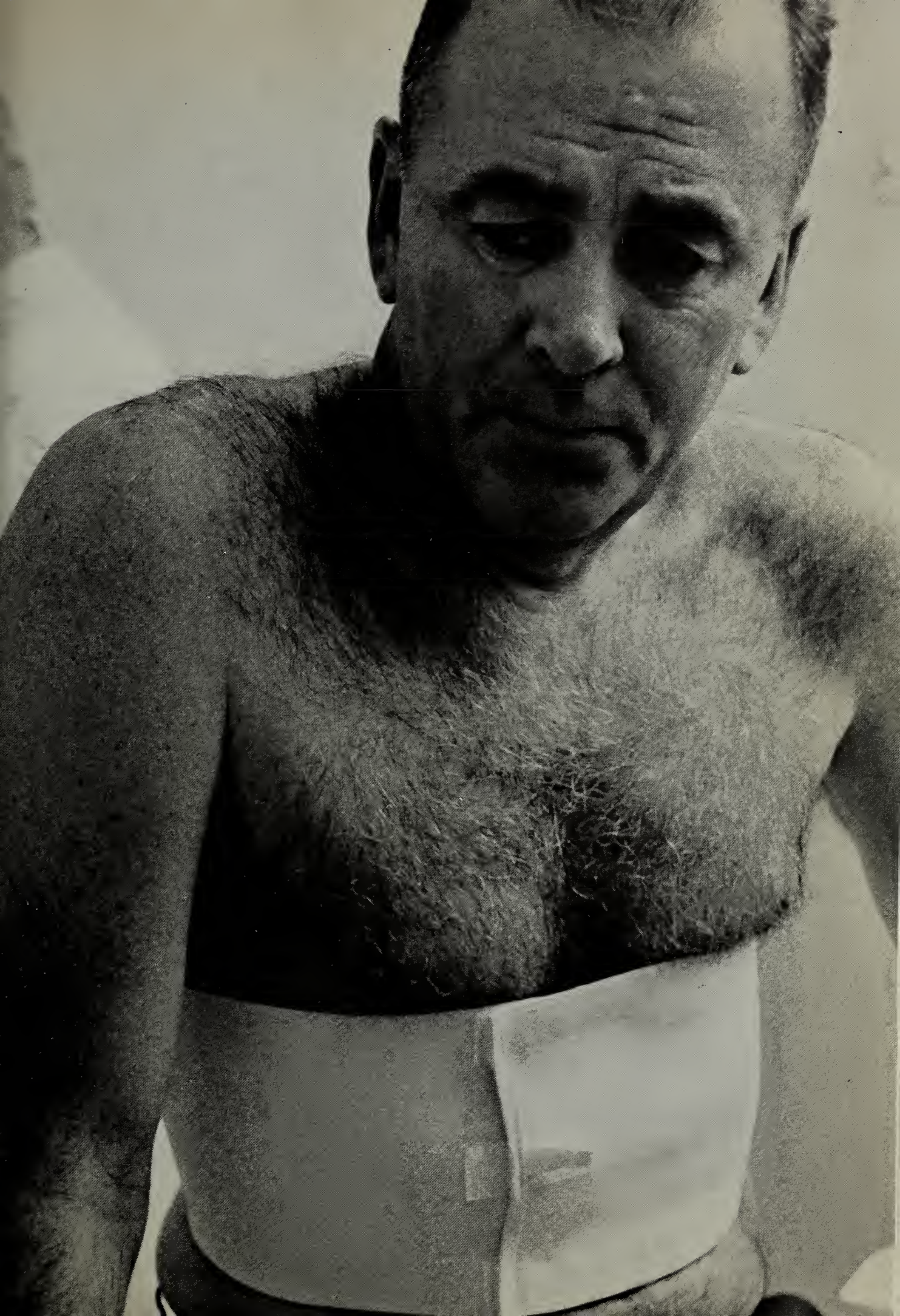
This increase in benefits will be announced to federal employees in Mississippi in a new brochure which is being prepared for this purpose.

Each Mississippi physician has received a letter from Blue Cross-Blue Shield announcing the change in the federal employees medical and surgical fee program. Complete information on the new program will be dissiminated through the various local medical societies. A slide presentation will be prepared, and time will be sought at local medical society meetings for a full explanation of the new program and to answer any questions that may arise.

Plan officials stated that it is the intent of the usual, customary and reasonable fee program to pay for the physician's covered services in full, provided the fee charged is the physician's usual fee and does not exceed the fee customarily charged by other physicians of similar competence and skill performing the same service in the same geographic-medical economic area.

A fee will be considered reasonable if it meets the usual and customary charges or is justified by special circumstances of the particular case in question.

The program is being established without attempting to secure participating agreements from individual physicians. Fee review committees, to be established throughout Mississippi through local medical societies, will be used to deal with



any disputed cases. Where no local committee exists, disputed cases will be turned over to an appropriate state-wide committee, according to the plan's announcement.

National accounts enrolled in Mississippi are also eligible for the usual, customary and reasonable fee program as outlined by the plan's executive committee. The expansion of this type benefits program to local Mississippi groups is contingent upon the success of the FEP program.

"The success and effectiveness of the usual, customary and reasonable fee program will be dependent on continuous cooperation among all parties, including the plan, the medical societies, and the federal employee group," Dr. Woosley said.

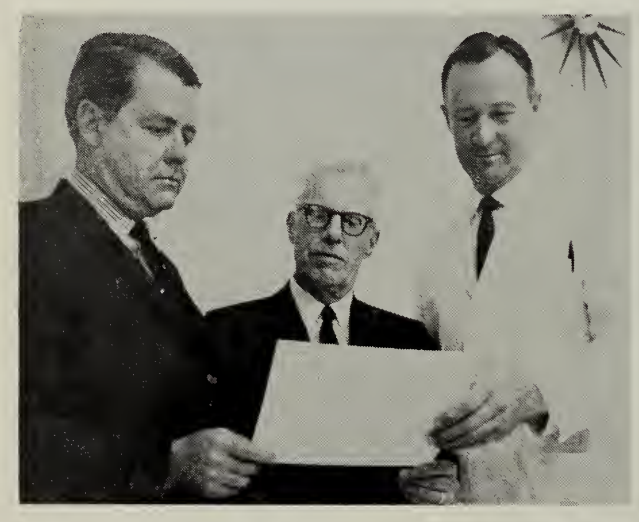
"Officials of Mississippi Hospital and Medical Service are pleased to offer this evidence of further progress in the upgrading of Mississippi Blue Shield benefits."

Dr. Kelsey Is First SMA Lecturer

The first lecturer of the Southern Medical Association Lectureship spoke at the University Medical Center in Jackson. Dr. Weston M. Kelsey, Jr., chairman of pediatrics at Bowman Gray School of Medicine, as a visiting professor of pediatrics, gave presentations on thyroid problems in children and the production of physicians' assistants.

The lectureship series was endowed by the Council of Southern Medical Association as a vital aspect of its overall program to underwrite excellence in postgraduate medical education. Presenting the distinguished lecturer to the UMC pediatrics department Dr. Howard A. Nelson of Greenwood, former Southern Medical Association councilor from Mississippi, introduced Dr. Kelsey and presented a SMA certificate of appreciation.

Dr. Robert E. Carter, director of the Medical Center and medical school dean, presided at the program. If the lecturers are well received, Southern Medical Association expects to offer the program to all the medical schools in the SMA states.



Dr. Howard A. Nelson, left, and Dr. Robert E. Carter, right, discuss the first SMA lecture by Dr. Weston M. Kelsey, Jr., at UMC.

PMA Underwrites New Drug Research

Scientists will be encouraged to conduct further studies "aimed at relating drug action with drug induced structure and function changes" as a result of fellowship awards announced by the Pharmaceutical Manufacturers Association Foundation.

PMA Foundation President C. Joseph Stetler called the awards "another program in an increasingly significant series of PMA Foundation contributions to medical and scientific progress.

"Recent developments in the field of cellular structure-function relations make it particularly important to conduct parallel studies of drug evoked changes in structure and their functional significance," Stetler said in announcing the program of 1969 awards.

Called the "PMA Foundation Fellowship Awards in Pharmacologic-Pathology," the program is designed to advance understanding of drug action through discovery of specifically related cellular and tissue changes. It also will encourage scientists to study associations between normal and abnormal function in particular tissue and cellular structures. The program seeks to support those individuals who, at the post doctoral level, will seek training in fields such as pathology or cytology with pharmacology.

The number of awards under the program will be limited to two or three a year. Each will provide a level of financial support aimed at keeping within the existing stipend levels for similarly trained individuals within the applicant university.

The awards are for two years each but, in exceptional circumstances, may be extended an additional year. Applications for the academic year beginning July 1, 1969 will be accepted until Feb. 15, 1969.

Dr. Grenfell Is New SMA Councilor

Dr. Raymond F. Grenfell of Jackson has been named a councilor of the Southern Medical Association as the second largest general medical association in the nation begins its 63rd year.

The recent annual meeting of the association was conducted at New Orleans and had a registration exceeding 5,000, among whom were 3,000 physicians. The 1967-68 president was Dr. Oscar B. Hunter of Washington, D. C. The newly inaugurated president is Dr. Donald F. Marion of Miami.

Dr. Grenfell limits his practice to internal medicine. He serves in the state medical association as chairman of the Committee on AMA-ERF.

Emory Will Emphasize Electives

Emory University medical students will have greater individual freedom in selecting their courses of study under new curriculum changes approved by the Advisory Faculty Council of the Emory School of Medicine. The elective opportunities will be offered largely in the senior year.

Dean Arthur P. Richardson of the medical school said the new curriculum will go into effect in August 1969, but implementation will come step by step. Students will thus have ample opportunity to plan their elective program for the senior year in 1970-71.

"Essentially these changes provide for increased flexibility in the training of physicians and will greatly increase the student electives," Dr. Richardson said.

"A student may now elect to take additional training beyond that given in required courses in one or more of the clinical areas, or he may decide to take additional academic work in the Division of Basic Health Sciences."

During his senior year, the student will be able to spend 50 per cent of his time in a faculty-approved educational program of his own choosing, the dean explained.

The changes follow guidelines proposed by the medical school's Advisory Faculty Council more than two years ago; they are also in keeping with recommendations adopted by the Association of American Medical Colleges at a meeting in Houston, Tex., earlier this month.

The AAMC urged that medical schools "individualize the education of the physician to fit the students' varying rates of achievement, various educational backgrounds and differing career goals."

Coast Counties Tap '69 Leaders

Physicians of the Mississippi Gulf Coast completed a busy agenda at their annual ladies' night pre-Christmas meeting by chartering a new component medical society, naming a new 50 Year Club Member, electing officers for 1969, and hearing the president of the state medical association.

After charter night ceremonies officially brought Jackson County into component society status as the Singing River Medical Society, Dr. G. T. Sheffield of Gulfport was honored by the Coast Counties Medical Society in his formal installation into the 50 Year Club. Dr. W. S. Sekul of Biloxi, host society president, read the citation, and Dr. Joseph B. Rogers of Oxford, MSMA president, formally presented the certificate and lapel pin.

Named to serve the Coast Counties group in 1969 were Dr. Andrew K. Martinolich, Jr., of Bay St. Louis, president; Dr. Richard F. Gates of Gulfport, president-elect; Dr. Edward C. Hamilton of Gulfport, vice president; Dr. C. Hal Cleveland of Gulfport, secretary-treasurer; and Dr. Paul L. Horn, Jr., of Ocean Springs, member of the Board of Censors.



Dr. G. T. Sheffield of Gulfport, center, accepts congratulations from two of his four sons on the occasion of his installation to the 50 Year Club of the association at Biloxi recently. Left, Dr. James A. Sheffield of Gulfport, a pediatrician, and right, Dr. Troy E. Sheffield of Gulfport, a dentist, commend their father.

Dr. Purvis Receives High Church Post

Dr. George D. Purvis of Jackson was named vice president of the Mississippi Baptist Convention Board for 1968-69. The church governing authority presides over the largest single denomination in the state.

Named to other officer posts were the Rev. Dr. Levon Moore, pastor of the First Baptist Church of Pontotoc, and the Rev. Dr. Bob Simmons of Meridian, pastor of the 15th Ave. Baptist Church of that city.

Dr. Purvis is a senior member of the Central Orthopaedic Clinic in Jackson. He is chairman of the state medical association's Committee on Occupational Health, a member of the Council on Budget and Finance, and a member of the House of Delegates.

Dr. Dorman Urges Insurance Changes

The need for more effective, economical and comprehensive voluntary health insurance was emphasized by Dr. Gerald D. Dorman of New York, president-elect of the American Medical Association.

Continuing improvements in health insurance are necessary to help alleviate the financial burden stemming from rising medical costs, he said. These costs are more than just a passing phase and should be so recognized by the medical profession and the insurance business.

Speaking before the annual meeting of the Association of Life Insurance Medical Directors of America in St. Louis, Dr. Dorman said one role of medicine and insurance is to "create an understanding" by the public of the whole changing pattern of health care and manpower, as well as of cost.

"We must achieve an understanding by the public that the multiplying factors of demand not only have stimulated increases in the cost of health care, but actually have forced the cost upward," he said.

The important thing now in the face of this demand, he said, is for private health insurance to meet the needs of the people by providing a wide choice of available coverages, and by being more effective, economical and comprehensive.

The latter objectives would entail coverage in extended care facilities, admitting patients to hospitals only when necessary, and performing pre and post-operative studies, he said.

A means of financing the public's expenditures for medical services, Dr. Dorman said, has been offered by the AMA Committee on Health Care Financing. One proposal was a community health care financing mechanism which would pool the community's funds and disburse them more efficiently through a community health services fiscal agency.

A second AMA proposal was for income tax credits to be given, on a graduated basis, for premiums paid for "adequate" health insurance. Persons without enough income to pay income tax, he said, would be issued government vouchers for this insurance.

Medical Assistants Win National Award



Margaret Bond of Gulfport, right, accepts the first place membership award from the American Association of Medical Assistants at the organization's recent 12th Annual Convention. Wilda Haines of Canton, Ohio, AAMA membership chairman, makes the presentation. The Mississippi Association of Medical Assistants enjoyed the greatest percentage growth in membership last year of any state group.

Dr. Berman Receives Medical Assistants Award

Dr. Maxwell D. Berman, Jackson general practitioner, was awarded the title "Physician of the Year" by the Central Mississippi Chapter, Mississippi Association of Medical Assistants at the Jackson Country Club in December.

Miss Martha Humphries, retiring president of the local chapter, made the presentation in the form of an engraved walnut and brass plaque during the organization's annual Bosses' Appreciation banquet.

Dr. Berman said that he believes the association to be "a great thing. It furthers the members' education and interest in the care of patients. Central Mississippi Chapter has grown; it is very energetic. They are planning for the future, trying to improve; this is good. All doctors should encourage their assistants to join."

A graduate of Johns Hopkins University and Vanderbilt University, Dr. Berman has been in the practice of medicine in Jackson for 33 years except for a period during World War II when he was a member of the U. S. Army Medical Corps.

Danny Thomas Is NIH Adviser

Danny Thomas, entertainer and television producer, has been named to the National Advisory Cancer Council by Dr. Robert Q. Marston, Director of the National Institutes of Health, Department of Health, Education, and Welfare.

The council, established by the National Cancer Institute Act of 1937, advises the director, NIH, on general policies, programs, and needs, and reviews Institute program developments and the status of cancer research. It also reviews and makes recommendations on applications for research and training grants. Thomas will be assigned to the Council's Subcommittee on Carcinogenesis and Prevention.

Thomas is the founder of St. Jude Children's Research Hospital, Memphis, Tennessee, and is a member of its national board of governors. The hospital is a non-profit research institution for the study of childhood cancer and other catastrophic diseases and for basic research in the life sciences.

A native of Deerfield, Mich., Thomas has been a professional entertainer for more than 30 years, in radio, night clubs, motion pictures and television. During World War II he was an overseas entertainer in the European Theater with Marlene Dietrich, and in the Pacific Theater with his own troupe. His television production, "The Danny Thomas Show," won five Emmy Awards between 1953 and 1963.

Two years ago, Thomas received the American Medical Association's Layman Award, the highest it can bestow on a nonmedical man, and awarded only six times in the last 20 years.

ACP Sets Meeting at New Orleans

Specialists in internal medicine in Louisiana and Mississippi will attend a regional scientific meeting of the American College of Physicians (ACP) in New Orleans, La., Jan. 31-Feb. 1.

The session, to be held at the Royal Orleans Hotel, is one of 35 scientific-educational meetings the ACP sponsors during the academic year. Held throughout the United States and Canada, the meetings help the College's 14,300 members keep abreast of developments in the basic sciences and clinical medicine.

Special guests will be Drs. Samuel P. Asper of Baltimore, Md., ACP president-elect and professor of medicine, Johns Hopkins University School of Medicine, and Edward C. Rosenow, Jr. of Philadelphia, Pa., ACP executive director.

Dr. A. Seldon Mann, M.D., New Orleans, La., ACP Governor for Louisiana and professor of clinical medicine, Tulane University School of Medicine, is in general charge of the meeting. Dr. Wesley W. Lake, Sr., of Pass Christian, Miss., is ACP Governor for Mississippi. Dr. Lake is assistant clinical professor of medicine at Tulane.

Three Communities Offer Measles Shots

Three additional Mississippi cities have sponsored measles immunization campaigns. Physicians and Auxiliary members at Hattiesburg, McComb, and Natchez have joined with community service organizations and agencies in the drives.

Public health officials estimate that the three cities have combined populations of more than 7,000 measles-susceptible children. The campaigns, carried out in pre-Christmas schedules, may have reached as many as half of the children.

At the 100th Annual Session, the state medical association's House of Delegates called on component societies and physicians to continue immunization efforts.





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Index to Advertisers

Blue Cross 28A
Burroughs-Wellcome 32A

Campbell Soup 12A
Ciba Pharmaceutical Co. 28B, 28C

Geigy Pharmaceuticals **8, 9, 10,** 32D
Glenbrook Laboratories **11**

Highland Hospital **7**
Hill Crest Hospital **6**
Hynson, Westcott, and Dunning **3**

Kay Surgical 36

Lederle Laboratories **4,** 20A, 20B
Eli Lilly **front cover, 14A, 14B**

New Orleans Graduate Medical Assembly **14**

Parke, Davis and Co. 20C
Pharmaceutical Manufacturers Association 29
Pitman-Moore 24B, 25
William P. Poythress 24A

A. H. Robins Co. **12,** 12D, **13,** 36
Roche Laboratories 32B, 32C, **back cover**

G. D. Searle center

Warner-Chilcott Laboratories 12E, 12F
Winthrop Laboratories 20D
Wyeth Laboratories **2,** 16A, 16B, 30, 31

Thomas Yates and Co. **inside back cover**

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CONTENTS

ORIGINAL PAPERS

Left Pulmonary Aplasia: A Case Report **37** JOHN D. COFFEY, M.D., and DAVID G. WATSON, M.D.

Erythema Multiforme Complicating Smallpox Vaccination **41** EDWARD G. SCOTT, M.D., and GEORGE A. PANKEY, M.D.

SPECIAL ARTICLES

Clinicopathological Conference XCIII **43** WILLIAM B. WILSON, M.D.

Radiologic Seminar LXXXI **50** CLIFTON L. HESTER, JR., M.D.

EDITORIALS

The Growing Crisis in Professional Liability Insurance **53** Premiums Zoom!

Sen. Javitts and the Issue of Malnutrition **54** Survey in N. Y.

1799 and the State of the Science **55** Washington's Terminal Illness

Sauce Béarnaise and Tomato Catsup **55** The 91st Congress

Mississippi M.D.'s Heed Dr. Ochsner **56** No Smoking, Please

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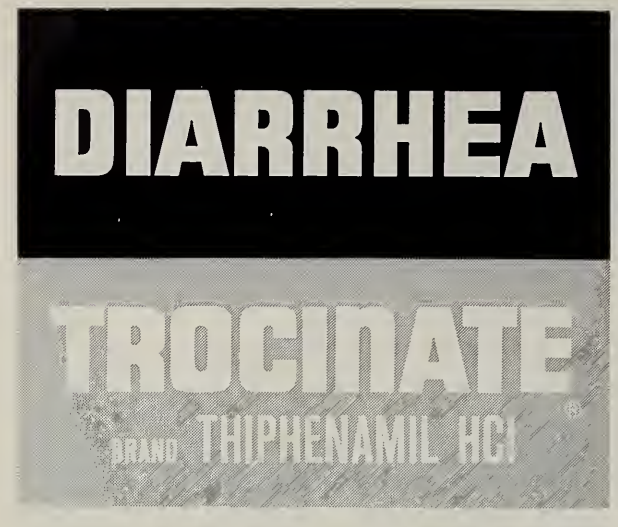
The President Speaking **52** A Two-Way Street

Medical Organization **61** Professional Liability

Officers, Trustees, and Councils **80** Official Listing

Meetings **82** Society Circuit

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Blue Cross Issues Magazine on Poor

"The health of the poor in the United States is a national disaster. The poor are likelier to be sick, the sick are likelier to be poor." So says Dr. H. Jack Geiger, professor of preventive medicine at the Tufts University School of Medicine in Boston.

"Now in the affluent 60's . . . it can truthfully be said that over one-third of this nation feels ill-cared for in its medical needs," says public opinion analyst Louis Harris.

"More money is spent conserving migratory birds than (the health of) migratory workers," says Dr. Stanley Skillicorn, director of the Santa Clara, California, Migrant Clinic.

"There is no point in training a boy to operate a tractor if you cannot repair the hernia that may keep him from being employed later on. There is no point in training a boy to work when employers view him as disfigured because all his teeth have been extracted." So says Dr. Joseph T. English, Office of Economic Opportunity assistant director for health affairs.

These are some of the pungent points made in the first issue of *Sources,* a new publication put out by the Blue Cross Association, the world's largest voluntary, nonprofit health pre-payment organization. The purpose of the publication, which will be distributed free to leading private citizens, public officials and other decision makers, is "to identify and give definition to vital health issues" of today, according to Walter J. McNerney, Blue Cross president.

"We hope that by sharing our knowledge with others, inside and outside the health field, we will contribute to a decision-making process that will result in better solutions that are an effective response to the problems," said McNerney.

In selecting the health problems of the poor—white, black and red—as the theme of *Sources'* first issue, McNerney explained, "We in Blue Cross have discovered that we know too little about the health problems of the poor," and added that Blue Cross is now working with many agencies in the private sector and government "to explore methods of making the health care system more efficient and improving its availability to every American, whether affluent or poor."

Contributors to the new publication include Senator Fred R. Harris of Oklahoma, public opinion analyst Louis Harris, and Mollie Orshansky, head of the Office of Research and Statistics of the Social Security Administration.

The 64-page pilot issue, 9 × 12 inches in size, is lavishly illustrated with photos, most of them the work of the well-known photojournalist, Art Shay. Editor is Richard M. Ralston.

Writing of the 45 million Americans now designated as poor or near-poor, defined as those in four-person families with income of $85 weekly or less, the SSA's Mollie Orchansky suggests that new public income-support programs or stepped-up extensions of existing ones are needed to combat poverty.

Official government figures are also cited to show that families with incomes under $2,000 have three times the incidence of disabling heart disease, five times as much mental illness, and nine times as many visual impairments as families with over-$7,000 incomes.

A 17-page study, made especially for *Sources* by Louis Harris, finds that worsening health is the foremost worry of the poor, Negro and white, a large majority of whom also believe that not enough medical care is available to them. The poor are also reported to resent the long waits and the impersonality of the kind of medical care dispensed at hospital clinics. Significantly, about 40 per cent, the Harris study also reveals, criticize the fragmentation of available services, expressing the view that "each part of the health care has to be found somewhere else."

Wyeth Funds Fertility Lectures

Wyeth Laboratories has established an exchange lectureship program for the Pacific Coast Fertility Society and the Canadian Society for the Study of Fertility.

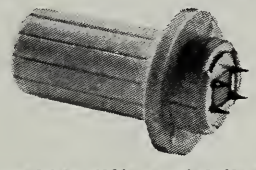
The Wyeth Exchange Lectureship Program provides that each of the two organizations will, at its annual meeting, select a paper to be read at the annual meeting of the other group. Wyeth will award $1,000 to each speaker selected to meet expenses connected with making the presentation. According to Herbert W. Blades, president of Wyeth, the goal of the new program is to increase the scope of medical information exchanged between the United States and Canada.

The first lecturer to be selected under the new program, Dr. Betty Poland of Vancouver, British Columbia, addressed the Pacific Coast Fertility Society during its annual meeting in Palm Springs, California. Dr. Poland spoke on "The Hazards of Embryonic Development in Early Spontaneous Abortion."

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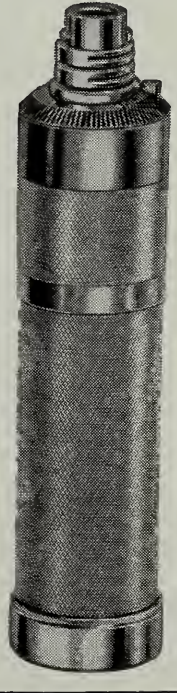
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION

JACKSON, MISSISSIPPI

February 1969

Dear Doctor:

Jackson's sometimes not-so-unanimous City Council has voted unanimously to fluoridate the capital's public water supplies. The action came in mid-January, and city officials estimate that modifications to water system for addition of fluorides will be operative by June.

> Project was presented to City Council by Dr. Jim G. Hendrick in behalf of Jackson Chamber of Commerce. Proposal carried support of medical, dental, public health, hospital, and civic groups. Jackson becomes 32nd city in state to fluoridate water supplies.

The concept of compulsory postgraduate medical education was extended in a recent action of an Oklahoma county society. Members of the East Central Oklahoma Medical Society must receive 30 hours PG training annually to maintain membership. Action is patterned along lines of Oregon requirement. By contrast, Mississippi supports voluntary PG programs with reward incentives.

The flu bug is on the wane in Mississippi, according to State Board of Health epidemiologists, who feel crest has passed. January highs were weekly reportings of 26,000 cases. Vaccine supplies are reaching adequacy as large segments of population have received protection. Hong Kong variant has turned up in counties along north-south axis from Harrison to Quitman.

Voluntary prepayment and health insurance paid beneficiaries a record $12 billion in benefits during 1968. So reports Health Insurance Institute, crediting Blue plans with $5.4 billion payout and insurance companies with $6.6 billion. HII says that scope of coverage and benefits paid will increase in 1969.

Typical activities of physician-volunteers in AMA-USAID Viet Nam program are depicted in a new sound film. Entitled "Bac Si My," the film runs 13 minutes and is available on loan to component medical societies.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

HEW Tightens Up Usual And Customary Fee Criteria

Washington - Eleventh hour changes in Medicare regulations by outgoing HEW Secretary Wilbur Cohen have tightened and toughened Part 1-B payment criteria for physicians' services. New rules make upward fee revisions difficult, require carriers to screen fee data more closely, to classify physicians by specialty and subspecialty in establishing charges, and to develop new broad bases of fee information. To date, Nixon administration has not modified ruling.

AMA Offers Data Service On Transplants

Chicago - The AMA Communications Division, public relations arm of the headquarters office, has established a special office to maintain accurate data on organ transplantation for mass news media. In addition to general statistics, cases include identity of surgeon, recipient, hospital where procedure was performed, and survival data. The news service reports 96 heart transplants during year following first Barnard procedure.

First Bill In New Congress Spotlights Medicine

Washington - The 91st Congress went into business with a bang as House members introduced 2,379 bills on opening day. The first, H.R. 1, by Rep. Hebert (D., La.), is the Uniformed Services Academy of Health Sciences Act of 1969, calling for establishment of school complex within 25 miles of Washington. Proposal would graduate 100 physicians annually within 10 years.

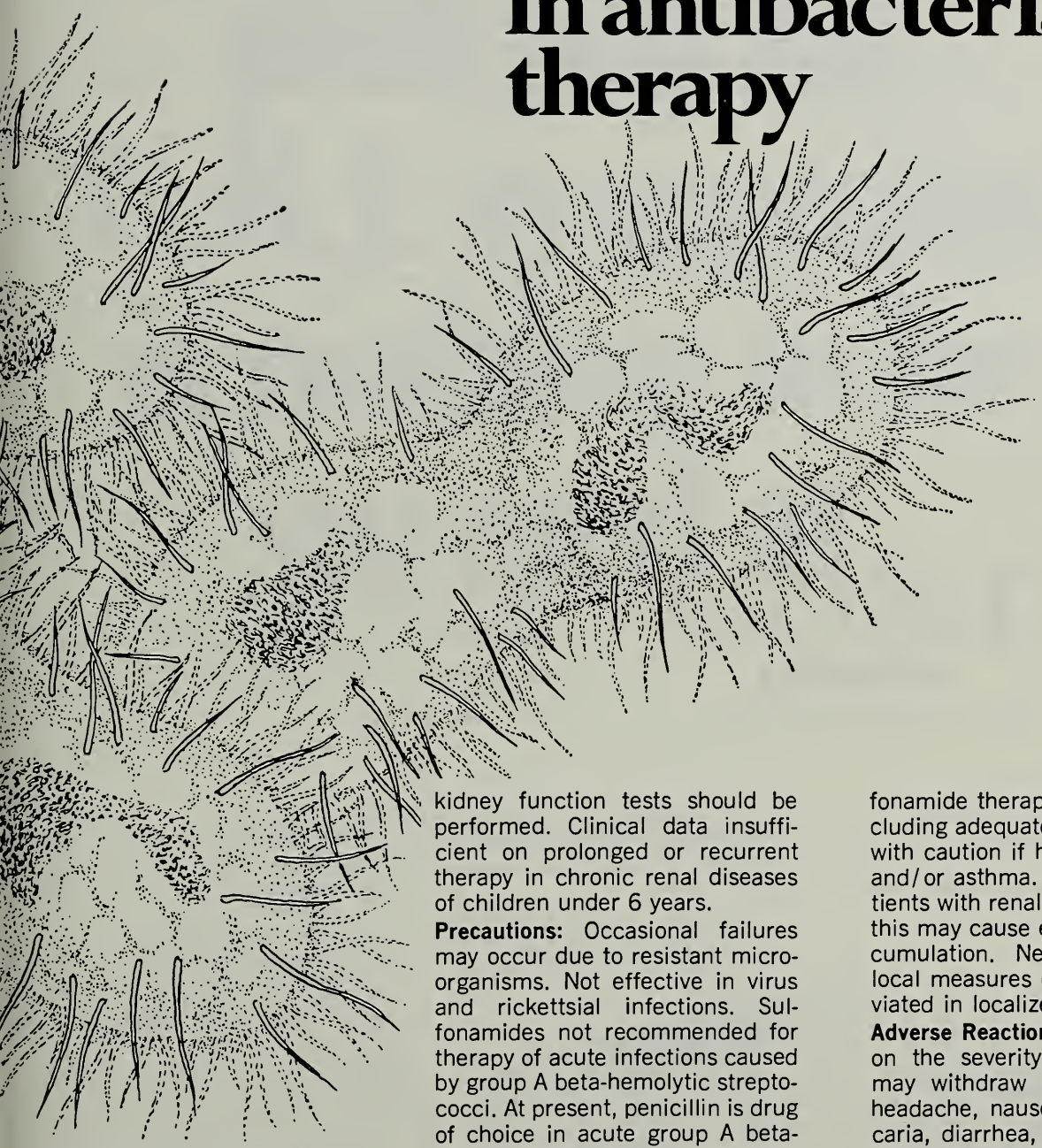
Dartmouth Gets Major Assist In New Medical School

New York - The Commonwealth Fund, a major $150 million foundation oriented to health and medical care, has given Dartmouth Medical School $750,000 as start-up money for developing a unique four-year school. Present school is a two-year medical certificate unit. New institution would offer shortened curriculum, train only general practitioners, and integrate internship into regular training.

IRS Lowers Tax Boom On Residents And Interns

Washington - In a surprise ruling, the Internal Revenue Service will henceforth not exclude payments from gross income of residents and interns in a hospital operated in conjunction with a medical school where patient care is determined to exceed teaching. Apparent result will be to place a new burden of proof on training institutions as to what their respective major thrust really is for tax purposes. Ruling is IRS Rev. Rul. 68-520, I.R.B., 1968-41, 8.

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kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

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AAP Urges Realistic Insurance Benefits

The American Academy of Pediatrics has urged that health insurance plans provide more comprehensive coverage for the delivery of medical services to infants and children.

The Academy's Subcommittee on Third Party Payment Plans has emphasized that today a major portion of child health care is not covered by health insurance.

The AAP statement defined comprehensive pediatric care as "all services given to infants, children, and adolescents necessary to establish and maintain optimal health."

"When indicated, these services should be rendered on a 24-hour basis by a personal physician or his aid acting under the physician's supervision either in the office, hospital outpatient department, or other facility," the Academy statement pointed out.

The AAP identified the following services as constituting comprehensive pediatric care for children:

Pre and postnatal care of all infants, including care rendered in the delivery room for "high risk births."

Diagnosis and treatment of disorders of growth and development.

Preventive care through periodic examinations and immunizations.

Anticipatory guidance and counselling.

Diagnosis and treatment of illness and injury.

Diagnosis, treatment and rehabilitation of patients with abnormalities both physical and mental, congenital, and acquired.

Diagnostic x-ray and laboratory services either in the office, hospital outpatient department, or other facility.

Consultations.

Concurrent care (simultaneous services by more than one physician or surgeon).

Consecutive care (continuation of services when the care of the patient is transferred from one physician to another).

Screening tests for vision, hearing, and intellectual development.

Psychiatric and psychological services, both diagnostic and therapeutic.

Utilization of community medical resources.

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Creighton Seeks Subjects in Cancer Study

The medical genetics section of the department of preventive medicine and public health at Creighton University School of Medicine, Omaha, is interested in the study of patients showing an increased incidence of any histological variety of cancer in their families. Of particular interest to investigators is the cancer family syndrome, characterized by: increased frequency of adenocarcinoma of all sites, particularly of the colon and endometrium, early age at onset of cancer, increased occurrences of multiple primary malignant neoplasms, and autosomal dominant inheritance.

To date, the project has investigated six families fulfilling all of the above criteria (Lynch, H. T., and Krush, A. J.: Heredity and Adenocarcinoma of the Colon, *Gastroenterology 53*: 517-527, 1967), and has corresponded with physicians in Europe who have described two separate and non-related families which also fulfill the criteria.

Physicians with patients known to have a familial cancer background, may write to Dr. Henry T. Lynch, Associate Professor and Chairman, Department of Preventive Medicine and Public Health, Creighton University School of Medicine. 657 North 27th Street, Omaha, Neb. 68131.

RMP Education Group Meets

A continuing education committee has been formed for the Mississippi Regional Medical Program to help plan and initiate appropriate educational opportunities for all Mississippi health professionals. Members, currently 26, are representatives of medical and allied health organizations in the state. MRMP postgraduate education coordinator is Dr. William O. Barnett, professor of surgery at University Medical Center. Dr. Guy T. Vise of Meridian, Dr. Dennis E. Ward of Corinth, and Dr. F. E. Tatum of Hattiesburg represent MSMA.

At the December organizational meeting at the Medical Center in Jackson, participants learned about the Mississippi Regional Medical Program and reported continuing education activities of their organizations.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1969, Vol. X, No. 2

ORIGINAL PAPERS

Left Pulmonary Aplasia: A Case Report

JOHN D. COFFEY, JR., M.D., and
DAVID G. WATSON, M.D.
Natchez and Jackson, Mississippi

The literature dealing with congenital absence of pulmonary tissue is reviewed. This shows a high incidence of associated anomalies and a high mortality, especially in early infancy. A case of left pulmonary aplasia, confirmed by bronchoscopy, bronchography, and angiocardiography, is presented. Chromosome analysis was normal, and the cause of the anomaly was not found. The patient has survived a stormy infancy and his prognosis now seems to be good.

Of the varying degrees of congenital absence of pulmonary tissue described by Salzberg,[1] pulmonary aplasia is the commonest variant and consists of a carina with a mainstem bronchial stump. Functionally, aplasia and agenesis (in which there is no carina) are similar.

Recinos and Waite[2] reviewed the literature in 1950, finding 45 authentic cases, the majority being post-mortem diagnoses. Several of these were incidental findings in adults dying of other causes. They added a case of left pulmonary aplasia, a 7-week-old male who died of respiratory failure from atelectasis and was found to have a left bronchial bud with rotation of the right lung lobes with the right upper lobe herniating into the left chest, and the right middle lobe into the posterior mediastinum, the right lower lobe occupying the right hemithorax. Other findings were absence of the left pulmonary artery, patent foramen ovale, congenital absence of the right kidney and ureter, left ureteral stricture with hydronephrosis, and seventh thoracic hemivertebra.

From the Department of Pediatrics, Natchez Medical Clinic and Jefferson Davis Memorial Hospital and the Department of Pediatrics, University of Mississippi School of Medicine.

That pulmonary agenesis is compatible with normal life and longevity is attested by the case reported by Netterville[3] in which the patient is now 18 years old and fond of horseback riding.

In recent years the percentage of diagnoses made during life has risen, but it remains true, as noted by Boothe and Berry,[4] that just under half of the patients with pulmonary agenesis die in the first year of life. The incidence of left and right lung absence is approximately equal. Prog-

nosis is poorer when the right lung is absent; accompanying heart abnormality is more commonly associated with right lung agenesis. They found a higher incidence of associated anomalies in their 17 cases than previously reported. Patent ductus arteriosus was the most common cardiovascular abnormality. Gastrointestinal abnormalities in their series included tracheoesophageal fistula, duodenal atresia, annular pancreas, Meckel's diverticulum, and imperforate anus. Ipsilateral facial or jaw abnormalities were present in six of eight living cases; absence of auditory meatus was noted in one. Ipsilateral upper limb abnormalities occurred in two of eight cases.

In the most recent report, Maltz and Nadas[5] reviewed 164 cases and added eight new cases; in their eight the right lung was absent. Six cases were diagnosed at autopsy and three by lipoidol bronchography and angiocardiography, one of these three confirmed at autopsy, one still living at age four years, and one still living at age six months. They note that the reason for separating hypoplasia of varying degrees from complete agenesis is both physiologic and prognostic and relates to the arterial unsaturation which may be present in a patient with hypoplasia due to the perfusion of underventilated lung segments; bronchography and angiocardiography are necessary for confirmation.

CASE REPORT

B.D. was delivered on April 10, 1967 of a 25-year-old gravida 3, para 2 mother by cesarean section, this being done because of a previous myomectomy. There had been a stormy gestational course characterized by maternal cramping and bleeding during the first trimester, a bout of gastroenteritis and two episodes of urinary tract infection during the second trimester, and a Group A beta hemolytic streptococcal pharyngitis in the last trimester. The mother's weight remained unchanged during her last trimester.



Figure 1. Newborn chest film showing absence of aeration in the left chest with shift of mediastinum of left and upper dorsal hemivertebrae.



Figure 2. Tracheobronchogram showing the short left bronchial stump and normal right bronchial tree. The esophagus is also outlined by swallowed contrast media.

Family history was negative for birth defects.

Birth weight was 5 pounds, 3 ounces. There was much amniotic fluid in the tracheobronchial tree, requiring repeated laryngoscopic tracheal aspirations. Mild respiratory distress syndrome followed, but subsided rapidly after supportive therapy including intravenous dextrose and bicarbonate solution.

Physical examination showed a shallow branchial cleft sinus on the right cheek, marked stenosis of the left ear canal, and dullness over the left chest with decreased breath sounds in the left

axilla. The palpable cardiac impulse was shifted to the left and there was a Grade I/VI systolic murmur. Both testes were undescended, and incomplete inguinal hernias were present. A normal Moro response was elicited with 90 db tone from the Infant Warblet Audiometer.

On April 12, 1967, chest x-ray (Figure 1) showed absence of aeration of the left chest with shift of the mediastinum and heart to the left, and hemivertebrae involving D-1 through D-4. Barium studies and intravenous urography showed the gastrointestinal and urinary tract to be grossly normal.

He had several hospital admissions in early infancy because of acute respiratory distress with infections, and required laryngoscopic and bronchoscopic aspirations and insufflation of oxygen for obstructive dyspnea and apneic bouts. Bronchoscopy showed a definite carina.

On August 28, 1967, a pilocarpine iontophoresis sweat test showed normal values (sodium 21.7 mEq/L, chloride 20.5 mEq/L).

A tracheobronchogram (Figure 2) using Dionosil Oily was done on September 15, 1967. This showed a short left bronchial stump and a grossly normal right bronchial tree.

On November 17, 1967, cardiac catheterization was done at the University Medical Center. This showed pressure in the right heart at the upper limit of normal (R.V. 30/4, P.A. 28/10), no evidence of shunt, and no arterial oxygen desaturation. Pulmonary angiograms (Figures 3 and 4) showed normal pulmonary arteries and veins on the right, and no such vessels on the left.

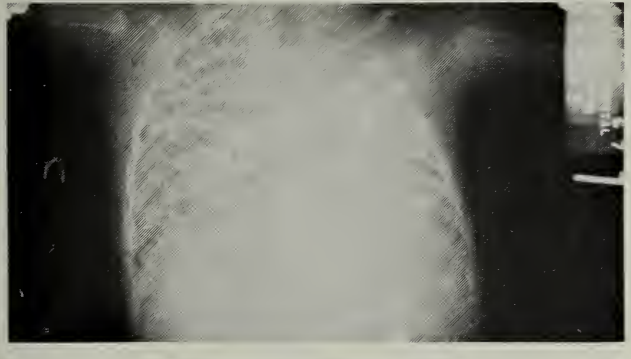


Figure 3. Pulmonary angiogram showing normal pulmonary arteries on the right, none on the left.

Chromosome analysis of peripheral blood by Dr. John F. Jackson of the University Medical Center showed a normal male karyotype.



Figure 4. Sequential film showing right pulmonary veins and left heart outflow.

His growth pattern has progressed steadily just below the 3rd percentile. At age 15 months his height was 27¼ inches, weight 19¼ pounds. At 16 months, he is beginning to walk alone.

He continues to have frequent bouts of brassy coughing and wheezing with respiratory infections, but, as he grows, they have become less distressing and have not required the rigorous measures used to salvage him in early infancy.

DISCUSSION

The etiology of this congenital disorder remains undetermined. The high incidence of associated abnormalities of other organ systems suggest generalized teratogenic factors affecting the embryo before the 5 mm. stage. A review of the literature describing syndromes associated with abnormal chromosome patterns reveals one case of pulmonary agenesis (right lung) in a male with Trisomy 16-18 syndrome.[6]

There is nothing in our patient's family history, prenatal history, or chromosome analysis to offer an explanation. ★★★

49 Seargent S. Prentiss Dr.
(39120) (Dr. Coffey)

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YOU'LL NEVER WALK ALONE

A distinguished obstetrician reports a substantial increase in multiple births. He believes that more twins are being born because children lack the courage to come into the present world alone.

Erythema Multiforme Complicating Smallpox Vaccination

EDWARD G. SCOTT, M.D., and
GEORGE A. PANKEY, M.D.
New Orleans, Louisiana

ERYTHEMA MULTIFORME is an unusual complication of smallpox vaccination. For this reason, the following case is reported.

CASE REPORT

A 34-year-old white Panamanian woman came to the Ochsner Clinic on July 11, 1967, complaining of pain and tenderness in the right upper abdominal quadrant.

The authors present a documented case of erythema multiforme secondary to a smallpox vaccination. They question the advisability of routine smallpox vaccination in this country in view of the lack of regularly repeated adult vaccinations, known complications, and rarity of the disease.

As an adult, the patient had had an urticarial reaction after an intramuscular injection of penicillin. She was taking no drugs and had no family history of allergy. She had had a smallpox vaccination six days before coming to the clinic.

On examination, an eye muscle imbalance, slight tenderness in the right upper abdominal quadrant, and a monilial infection of the right index finger were noted. The smallpox vaccination site did not appear unusual. The only abnormal findings on routine investigation for the abdominal pain was a large gallstone.

Twelve days after the smallpox vaccination, the patient returned to the office. She had a large vesicular, hemorrhagic lesion of the left arm at the vaccination site (Figure 1) and several other lesions on the upper thorax and arms (Figure 2). These lesions had a raised, erythematous border with central clearing. Histologic examination of a



Figure 1. Skin lesion of the vaccination site.

From the Department of Infectious Diseases, Ochsner Clinic and Ochsner Foundation Hospital.

biopsy specimen showed slight flattening and focal degeneration of the basal and prickle cells with very pronounced perivascular infiltration, mostly of round cells, in the upper and middle dermis. This was interpreted as erythema multiforme. The patient had no discomfort, and the lesion subsided without specific treatment.

Neff and associates[1] recently outlined the complications of smallpox vaccination. In view of these sometimes fatal complications, indiscriminate use of this vaccine has been questioned. In fact, some well-recognized contraindications have been enumerated: pregnancy, dermatitis, chickenpox, malignant neoplastic disease, adrenal steroid treatment, antimetabolite treatment, or living in close quarters with persons having any of these conditions. It is urged that the known complications be kept in mind, that the known contraindications be heeded, and that any unusual reactions to smallpox vaccination be reported.

SUMMARY

A documented case of erythema multiforme secondary to a smallpox vaccination is presented.

The advisability of routine smallpox vaccination is questioned in view of the lack of regularly repeated adult vaccinations, known complications, and rarity of the disease. ★★★

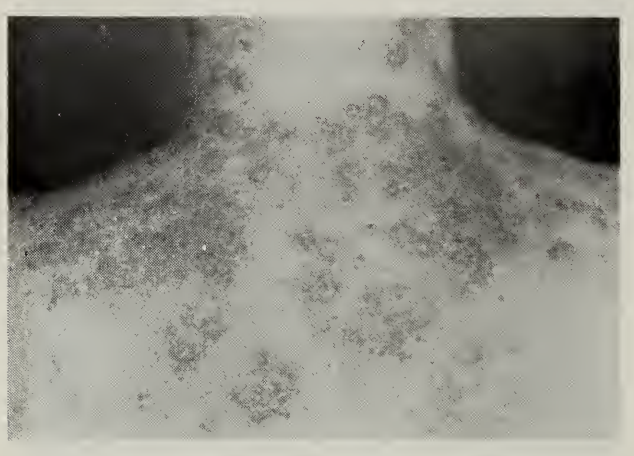


Figure 2A. Upper back lesions showing raised, erythematous border with central clearing.



Figure 2B. Skin lesions of right arm compatible with erythema multiforme.

1514 Jefferson Highway (70121)

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DETERRENT POWER

There is a new organization known as Bachelors Anonymous. Whenever a member feels that he is about to propose marriage, he calls the 24-hour answering service, and BA sends over a woman attired in a housecoat with her hair in rollers.

Clinicopathological Conference XCIII

WILLIAM B. WILSON, M.D.
Baptist Hospital, Jackson, Mississippi

THIS 59-YEAR-OLD white man was admitted to the Baptist Hospital for the first time at age 56 for posterior myocardial infarction, which was well documented, and which responded to treatment. At that time his blood pressure was 160/90, and he was somewhat obese. The VDRL was 4+ reactive. No chest film was obtained on that admission. After discharge he stopped smoking.

He was next admitted at age 59, because of weight loss and fever. During the two months prior to admission he had lost nine pounds but had not been on a reducing diet. For six weeks before admission he had had a severe cough, but no sputum production, hemoptysis, or pleurisy. For one to two weeks before admission he had had episodes of getting hot all over in the late afternoon, followed by chills. Systems review was unrevealing.

On examination he did not appear to be acutely ill, although there was evidence of recent weight loss. Blood pressure was 144/90. No rash or lymphadenomegaly was found. The lungs were resonant throughout. A few fine rales were heard in both bases, but no wheezes or tubular breathing. The heart was not enlarged and no murmurs were heard. The abdomen appeared somewhat obese, but no masses were felt. There was a small femoral hernia. Rectal examination was unrevealing. The extremities showed no clubbing, petechiae, or joint tenderness. Varicose veins were present in the left leg.

Admission white count was 14,700, with 84 per cent segs. Hemoglobin was 12.1 gm. per cent and hematocrit 39 per cent. Sedimentation rate was 50 mm/hr. Urinalysis was normal. BUN, blood glucose, cholesterol, SGOT, bilirubin, and cephalin flocculation were normal. The alkaline phosphatase was 7.2 Bodansky units, serum protein 6.9 gm. per cent, albumin 3.3 gm. per cent, and globulin 3.6 gm. per cent. Urine, sputum, stool, and five blood cultures were unrevealing on routine culture. Febrile agglutinins, heterophile, and LE tests were unrevealing on one examination each. Stool showed 1+ occult blood, but no ova or parasites on three examinations. Histoplasmin skin test was slightly positive. Tuberculin test was negative on several occasions. Bone marrow examination showed normal differential with

The patient in CPC XCIII is a 59-year-old white man admitted because of weight loss and fever of undetermined origin. Discussers are Drs. G. Boyd Shaw, Ottis G. Ball and William B. Wilson.

no abnormal cells, and no growth on routine, AFB, and fungus cultures. The VDRL was positive at 1:16 dilution.

The electrocardiogram was within normal limits, showing generally low T-waves. Chest film showed a moderate increase in the AP diameter of the chest, with mild generalized emphysema of the senile type. Heart size was normal. There was mild elongation of the aorta. In both lung bases, but more so on the right, there was a mild reticular pattern, which, when compared with old outside films, was diagnosed as chronic interstitial fibrosis. No pleural fluid was present. Repeat chest films showed no change. Upper GI series showed a sliding hiatal hernia. Small bowel series, gallbladder, barium enema, and IVP were normal. X-rays of the teeth showed extensive caries.

The patient was in the hospital for about one month. Each day at 4 or 8 p.m. the oral temperature spiked from a base line of 98 to 99 degrees to 101 degrees usually, sometimes only to 100 degrees, and sometimes as high as 102 de-

grees, which it never exceeded. Aspirin was usually given for fever after which the temperature dropped. Tetracycline therapy had no effect on the fever curve. The respiratory rate was consistently recorded at 16 to 20, and the pulse rate from 70 to 90. While in the hospital, the patient was troubled by a prolonged episode of hiccups. An aortic, systolic murmur appeared, and a barely palpable spleen was questionably detected.

His antibiotic therapy was changed to 40,000,000 units of penicillin by IV drip q12h and 1 gm. streptomycin IM q12h. This produced no change in his fever after one week's trial. He was then switched to chloramphenicol 250 mg. QID for five days, again without results. Just before discharge, the hemoglobin was recorded at 11 gm. per cent, the hematocrit at 34 per cent, and the WBC at 13,200, with 78 per cent segs and 5 per cent bands. The BUN and urinalysis remained normal. The alkaline phosphatase was not repeated.

EXPLORATORY LAPAROTOMY

Three weeks after discharge he was readmitted for exploratory laparotomy. He had continued to run fever up to 102 degrees each afternoon. His weight during his three-month illness had now dropped from 200 to 170 pounds. No further symptoms had developed. On examination, the patient did not appear acutely ill, but showed evidence of recent weight loss. A short, apical, systolic murmur was heard. The lungs were clear, and no masses or organs were palpable in the abdomen. The white count was 13,400, with 80 per cent segs, 15 per cent lymphs, and 5 per cent monocytes. The hematocrit was 36 per cent, hemoglobin 11.8 gm. per cent, and sed rate 54 mm/hr. Urinalysis was negative. Febrile agglutinations and three consecutive daily blood cultures were negative. An exploratory laparotomy was unrevealing. The afternoon temperature elevation persisted.

After discharge, the patient was initially treated with aspirin, but without effect on the fever. Mild anemia developed. Liver function studies remained normal or essentially unchanged and liver scan was normal. Steroid therapy was started two months after the laparotomy. His appetite improved, but fever persisted intermittently, accompanied by nightsweats. Three months after the laparotomy, his weight was 143 lb., and he had a one-month episode of superficial phlebitis in the varicose veins of his left leg. He began having recurrent attacks of rapid pulse, which was diagnosed by EKG as atrial tachycardia.

He also began having pain up and down his entire spine, and frequent attacks of "diffuse chest pain," with cough productive of thick, white sputum. A chest x-ray was said to show "evidence of a good deal of consolidation in the right middle lobe, and suspicious evidence of adenopathy in the right hilar area." Later, bilateral pedal edema developed, attributed to the steroid therapy, which had gradually been raised to 40 mg. prednisone per day.

FOURTH ADMISSION

Five months after his laparotomy, he was readmitted with paroxysmal atrial tachycardia. On examination he appeared chronically ill. The heart was not enlarged, and the rate had returned to normal. A grade 3/6, pansystolic murmur was heard at the base. The abdomen was soft, with no palpable organs or masses. Lab work showed a white count of 17,800, with 87 per cent segs, 10 per cent lymphs, 3 per cent monos. Hemoglobin was 10.8 gm. per cent and hematocrit 36 per cent. Sed rate was 38 mm/hr. Urinalysis was negative. Serum potassium was 4.2, and sodium 132 mEq/L. The VDRL was reactive in a 1:2 dilution. The electrocardiogram showed a sinus rhythm, with digitalis effect and myocardial ischemia. Steroids were continued during his brief hospitalization, and the temperature was recorded as 101 degrees orally at 8 p.m. on the night of admission.

The patient's final admission was one month later. On examination he appeared acutely and chronically ill, with evidence of marked weight loss. A few fine rales were heard in each lung base. No heart murmur was heard at this time, and the heart was not enlarged. Abdominal and rectal examinations were negative.

LABORATORY FINDINGS

Laboratory work showed normal urinalysis, white count 22,800, with 80 per cent segs, 6 per cent bands, 1 per cent metamyelocytes, 3 per cent monos, 8 per cent lymphs, and 1 per cent eosinophils. The hemoglobin was 12.8 gm. per cent and hematocrit 38 per cent. The alkaline phosphatase was 9.5 Bodansky units, BSP retention 22 per cent, SGOT 72, serum albumin 2.9 gm. per cent, and globulin 3.1 gm. per cent. The glucose, bilirubin, CO_2, potassium, and prothrombin time were normal. The SGOT dropped to normal after one week, while the BUN gradually rose to

38 per cent over the next month. Three weeks after admission serum sodium was recorded at 124 and potassium at 3.8 mEq/L. All other chemistries remained normal or unchanged, as did the hemogram and urinalysis. Routine sputum culture was normal on two occasions, a blood culture was sterile, and five smears of the sputum for AFB were negative. The AFB and fungus cultures had not shown growth at the time of the patient's death.

X-ray films on this admission showed a significant progression of the pulmonary infiltrate since the last examination six months previously. There was a fibrotic infiltrate in the periphery of the right upper lobe, and there was a question of some small cavities here, although the radiologic picture was not considered typical for tuberculosis. The old fibrotic infiltrate in the bases was essentially unchanged. There was also some widening of the mediastinum in the six months' interval since the last film.

A lung scan showed generalized diminution of uptake in the right lung, with increased uptake in the right apex, considered to be non-specific findings. Two weeks later a chest film was thought to show a cavity in the area of the right upper lobe infiltrate. One month after admission chest x-ray showed fullness of the hilar trunks bilaterally with apparent engorgement, and shadows of increased density in both lung fields which were thought to be on a congestive or inflammatory basis. There was also thought to be some inflammatory change on the left, and some emphysema in the right upper lung with the previously mentioned infiltrate.

CONDITION DETERIORATES

While in the hospital, the patient developed some confusion, cyanosis, substernal chest pain, and "sudden deterioration," with premature ventricular contractions and loud P_2. Respiratory rate was recorded consistently at 18-20. There was some tenderness in the left groin.The lung scan did not show emboli. He was started on heparin and dextran. At other times he complained of chest discomfort, choking, and pain in the dorsal spine on motion. He also had two seizures. Paroxysmal atrial tachycardia, confirmed by EKG, persisted despite digitalization. He developed atrial fibrillation and congestive failure, and died a month after admission.

Dr. G. Boyd Shaw: "To summarize, this is a 59-year-old man whose symptoms began approximately 11 months prior to death, and who was admitted several times in an effort to diagnose the problem. First, may we see the x-rays."

Dr. Ottis G. Ball: "A chest film on the first admission obtained on October 29, 1966 was essentially normal except for minimal chronic pulmonary fibrosis in the right upper lobe area. Chest films continued to be normal until the admission on June 24, 1967 at which time there was seen to be hazy infiltrate in the right lung apex with some interspersed radiolucencies having somewhat of a cavitary appearance. The lung fields were otherwise clear and the chest otherwise appeared normal. A lung scan revealed a relative perfusion deficiency throughout the right lung area. This was considered to be non-specific, however.

LAST X-RAY STUDY

"The last chest x-ray obtained on July 21, 1967 just prior to death revealed a rather diffuse hazy infiltrative process in both lung fields which on close inspection demonstrated a somewhat fine nodular appearance with some coalescence of this nodularity in the lower lung areas, particularly in the medial portion of the right lower lobe. This was considered to be an alveolar type pulmonary infiltrative process. The differential diagnosis is considerable with this type finding and would include miliary tuberculosis, alveolar cell carcinoma of the lung, metastatic carcinoma to the lung, possibly pulmonary blastomycosis; a lymphomatous process is sometimes demonstrated in this manner. Pulmonary sarcoidosis would be considered to be a less likely possibility.

"There was no radiographic evidence of adenopathy although the hilar areas were slightly full and the cardiac shadow was slightly larger than on previous examinations. An upper GI series performed on the first admission revealed a soft tissue mass in the left upper quadrant of the abdomen which was thought to represent splenic enlargement. The upper GI series was otherwise normal. The colon examination and IVP were normal."

NO LOCALIZING SYMPTOMS

Dr. Shaw: "So, we don't get a great deal of specific help from the x-rays. This patient was initially admitted with a fever of unknown origin, and there were no definite, localizing, symptoms, or signs throughout this illness. The laboratory findings included a persistent leukocytosis throughout, fairly normal liver function tests, and a positive serology which he had had some two years previously, and which was repeatedly positive. Shortly after the first admission he was found

to have a murmur, and this, of course, brought up the possibility of subacute bacterial endocarditis.

"The patient had initially been tried on a course of tetracycline therapy, apparently more or less empirically, and was then empirically started on treatment which we normally consider as adequate for SBE, 40,000,000 units penicillin and 2 gm. streptomycin daily. After one week of this, there was no change in the course and this therapy was discontinued. A fourth antibiotic, chloramphenicol, was tried for a period of five days, again with no definite results. The patient was then discharged home.

"After three weeks, he was readmitted for an exploratory laparotomy. Apparently, the thinking was that the patient had a malignancy and most likely a malignancy of the pancreas. I am assured that the laparotomy was indeed negative, that nothing at all was found, and I would assume that this also includes the retroperitoneal space, that there was no significant adenopathy and that fairly good palpation of the kidneys was accomplished. Nevertheless, he went home, again with his murmur, and returned several times later and had the x-ray changes that were described to you before. His death was preceded by confusion, cyanosis, substernal pain, but he apparently lingered for a short period of time—and we will speculate on the cause of demise.

FUO DIFFERENTIAL DIAGNOSIS

"Really, what we are dealing with is the differential diagnosis of fever of unknown origin, and when we approach a problem like this, I think it is helpful in organizing your thoughts to try to break it down into major categories of disease. One category would be collagen-vascular diseases. These include rheumatoid arthritis, rheumatic fever, lupus erythematosus, scleroderma, dermatomyositis, and polyarteritis. Now, there are certain findings that favor this category. One is the positive VDRL. I believe this is a false positive VDRL in this particular case, due to a nonspecifically elevated globulin. He had a globulin of about 3.6 on one or two determinations. However, at no time were any type of bone, joint, muscular, or skin changes described clinically. And so this leaves us wondering a little about this. I'll reserve polyarteritis for later comment.

"Secondly, certain endocrinopathies can cause a fever of unknown origin, specifically thyrotoxicosis. Many of us have seen patients in thyroid storm, and these patients are severely febrile. Thyroiditis may produce a febrile patient. But certainly there is nothing here to support this. Another endocrinopathy recently described is etiocholanolone fever, which is an abnormality in the breakdown of androsterone. This, I think, is a rather distant possibility and I will not consider it further.

HEMIC DISEASES

"A third group of diseases that can cause a fever of unknown origin are the hemic diseases, specifically leukemia, lymphoma, and myelofibrosis. Splenomegaly is suggested radiologically, but at no time are we told of any significant adenopathy. A mild elevation of the globulin would be consistent with this, but somewhere along the line we would like to see palpable nodes in the neck, on the chest x-ray, at laparotomy, or something else to help us with the diagnosis of a lymphoma. A bone marrow was done which was reportedly normal. We have no reason to doubt this, though sometimes we can get a normal bone marrow aspiration, and if we do a bone marrow biopsy—actually remove a piece of the marrow—we may be better helped by the information that this furnishes.

"The next category is solid tumors. We have all seen various types of carcinoma that can produce fever—carcinoma of the stomach, carcinoma of the colon, carcinoma of the kidney, carcinoma of the pancreas, and carcinoma of the lung. We will return to some of these in a minute. Fifth, and by far the most common, are various types of infections. Could bacterial endocarditis do this? The patient received a week of treatment, but it's conceivable that the organism was resistant to these drugs or the drugs were not continued for a sufficient period of time. I think this is unlikely in view of the entire course. Usually in a case of bacterial endocarditis we see progressive valve destruction, with progressive congestive heart failure, and this did not appear to be the case.

GRANULOMATOUS DISEASES

"Certainly the granulomatous diseases have to be considered. The various fungal diseases, histoplasmosis, blastomycosis, and cryptococcosis, can produce fever, and the patient was apparently empirically started on steroids, bringing up the possibility of 'opportunistic' fungi which may be a complicating factor in this type of problem. And certainly we cannot exactly disregard the positive VDRL; we must ask ourselves 'is this syphilis?' I have no great experience in this field. I do not believe it is.

"If we have to explain the murmurs by postu-

lating luetic aortitis, we would expect to find the diastolic murmur of aortic insufficiency, rather than the systolic murmur described. Also, the VDRL terminally was reduced in titer from a high of 1:16 on the first quantitative report to a titer of 1:2, and this is consistent with the so-called acute biological false positive.

"We usually think of sarcoidosis as a rather benign condition without causing any type of fever, but many of the problem cases of sarcoid have been diagnosed late because we thought it did not cause fever, and there are many features about this case that point to sarcoidosis. Finally, pulmonary embolus has to be considered strongly. The patient had migratory phlebitis. I'm not completely satisfied with this diagnosis because the picture of progressive right heart failure and cor pulmonale is not described in the protocol.

"We've listed a large number of things; let's try to narrow it down just a little bit more. What are the most likely possibilities in this patient? I have recently seen two cases of polyarteritis that ran much this same course, if not a more rapid course. The two things favoring polyarteritis are the persistent leukocytosis, otherwise unexplained, and splenomegaly. Against this diagnosis is the absence of skin involvement, renal involvement, and evidence of arterial thrombosis.

"Could this be a lymphoma? We know that a retroperitoneal lymphoma can cause us great diagnostic difficulty. We have very poor methods of determining its presence, but I would think the negative laparotomy, the normal IVP, the absence of lymph nodes is evidence against lymphoma. Sarcoidosis could certainly cause this picture. We have failed to mention the recurrent paroxysmal atrial tachycardia which the patient had on several occasions. Sarcoidosis might give this x-ray picture. It might give you recurrent arrhythmia. The patient received steroids which classically produce improvement in sarcoid. If we diagnose sarcoid, we must diagnose a complicating problem which could cause his downhill course. I do not believe this is what happened.

PULMONARY TUBERCULOSIS

"Did this patient have pulmonary tuberculosis? He started off with a negative skin test. We are never told of any more skin tests. He had a cavitary right upper lobe lesion in the place where he had old disease present prior to his illness. We would not be able to explain the negative skin test if we said this was re-infection TB, but I think we must strongly consider this possibility, especially in view of the steroid therapy. I do not think this is the picture of chronic, recurrent, pulmonary embolization. We do have phlebitis present in this dreadfully sick man. I think the terminal episode may have been a pulmonary embolus, but the entire illness is not typical of recurrent emboli.

KIDNEY CARCINOMA

"What about carcinoma of the kidney? We like to think that the IVP would help rule this out; we have no urinary tract findings. Yet we can find case reports of patients who have a small hypernephroma with a tremendous febrile response from the beginning and only quite late in the game will the tumor produce the characteristic x-ray picture. We may have this with metastatic disease in this patient.

"Finally, we come to what my diagnosis would be in this patient. I believe he has carcinoma of the lung. How do we explain the absence of radiologic findings? I believe we had a case in a CPC here last year that was presented with what the radiologist interpreted as an essentially normal chest x-ray who died of rather extensive bronchogenic carcinoma with extensive metastasis into the mediastinum, and I think this is most likely in this patient. Is it a squamous cell or is it an alveolar cell? Alveolar cell usually is a multicentric type of lesion, and I think I'll go out on a limb and say perhaps this was an alveolar cell type of carcinoma. In any event, I think the patient's disease is most likely neoplastic."

Dr. William B. Wilson: "I would like to congratulate Dr. Shaw on arriving at the correct diagnosis in this case. The patient had a bronchogenic carcinoma, which was a lemon-sized mass arising from the medial segment of the right lower lobe and also involving the anterior segment. There were metastases to the adjacent lower mediastinum, around the esophagus, and into the retroperitoneal area behind the stomach and involving the splenic vessels. There were hilar lymph node metastases, with nodes up to 3 cm. across, and metastases to the spleen, left adrenal, and bone marrow, but not to the liver or brain. There was a massive metastatic involvement of the pericardium involving the cardiac atria primarily, with a large pericardial effusion. The heart weighed 600 gm., of which 200 gm. were estimated to be tumor mass, adherent primarily to the left atrium.

"The first slide shows an overall view of the carcinoma, microscopically. These cells show, in areas, a pavement-like, random arrangement, with large vesicular nuclei and abundant cytoplasm, all typical for epidermoid carcinoma. Other areas show a less frankly epidermoid pattern,

which is commonly found in bronchogenic carcinoma. The next slide shows poorly differentiated tumor, with the large bizarre tumor cells, which probably could be objectively classified as poorly differentiated epidermoid carcinoma, although the histologic appearance is not as clear-cut as in the previous slide. This is a pleomorphic carcinoma, and bronchogenic carcinomas usually show a rather variable pattern from area to area.

"The lungs showed a thin-walled cavity in the right upper lobe, 5 cm. across, with a smooth, shiny, internal lining, and some induration of the lung tissue for a 1 cm. wide zone around the main cavity, gradually blending off into the rest of the pulmonary tissue. The lung tissue generally was somewhat fibrotic. The lower lobes showed some congestion bilaterally. Microscopic examination from the apical cyst showed no evidence of tuberculous etiology, and its nonspecific fibrotic character, along with the generally fibrotic and emphysematous appearance of the lungs grossly and microscopically, left us with the diagnosis of emphysematous cyst of the right upper lobe. In addition to the metastatic carcinoma, the heart showed a high lateral, left ventricular, old myocardial infarction.

"The liver was enlarged, weighing 2,400 gm., with blunting of the edge. Multiple cross sections showed a nutmeg type appearance throughout, but no tumor. Microscopically, this was a subacute passive congestion. The spleen was enlarged, weighing 400 gm., and showed several nodular tumor masses throughout the substance, and a triangular, 4 cm. area of reddish infarction. The left adrenal showed a metastatic tumor nodule 3 cm. across. The kidneys were essentially normal. Microscopically, tumor infiltrate was seen in the bone marrow. There was a diffuse myeloid hyperplasia and reticulum cell hyperplasia, also.

DIAGNOSIS OF FUO

"As for clinicopathologic correlations, I have attributed his entire illness, and the fever of unknown origin, to the occult bronchogenic carcinoma, in the absence of other anatomical findings which would explain the fever. The epicardial and pericardial metastases undoubtedly accounted for his recurrent atrial arrhythmias, and the mediastinal metastases probably accounted for his vague chest pains. The pericardial involvement also appears to have caused the chronic passive congestion of the liver, resulting in his elevated BSP retention, bilirubin, and alkaline phosphatase terminally, although I am not sure this accounted for the slight elevation of the alkaline phosphatase seen in the early part of his illness.

SPLENIC INFARCT

"The splenic infarct may have been due to the enlargement of the spleen by passive congestion, although this is not usually considered a cause of splenic infarction. In this case, involvement of the splenic vessels by the high retroperitoneal tumor metastases probably contributed to the passive congestion and development of the infarct. The finding, in the latter part of his illness, of a markedly low serum sodium raises the possibility of inappropriate secretion of antidiuretic hormone, secondary to the bronchogenic carcinoma, although this is only speculative. The episode of thrombophlebitis probably was due to the occult carcinoma, and in this connection, it is interesting that the thrombophlebitis involved only the superficial veins, and not the deep veins, of the leg, which is said to be characteristic of thrombophlebitis presenting as a sign of occult malignancy.

"My interpretation of the positive serology was late latent syphilis, with reduction of the serologic titer following the course of penicillin. The fairly high titer (1:16) of the VDRL is against the diagnosis of biologic false positive serology. I found no anatomic evidence of tertiary syphilis, however, and therefore cannot be dogmatic on this point, in opposing Dr. Shaw's interpretation of biologic false positive. The invasion of the bone marrow by metastatic tumor and the hyperplasia of reticulum cells and myeloid cells, apparently as a non-specific response to the tumor invasion, accounts for the immature leukocytes seen in the peripheral blood terminally.

"Petersdorf and Beeson reported their prospective analysis of 100 cases of fever of unknown origin, in a classic article.[1] They had one case attributed to a small hypernephroma. They also pointed out that primary carcinoma of the stomach is frequently associated with fever. Most of their cases of FUO which eventually turned out to be due to malignancy were associated with leukemia and lymphomas, however. About one-third of their cases of FUO were associated with infection, of which tuberculosis was the most frequent. Subacute bacterial endocarditis, liver and biliary tract infections, pelvic inflammatory disease, and pyelonephritis were the next most common. Besides infections and neoplastic diseases, collagen diseases, benign non-specific pericarditis, hypersensitivity states including poorly defined hepatitis syndromes, drug fever, 'periodic' diseases, cranial arteritis, thyroiditis, Weber-Chris-

tian disease, and other poorly defined and poorly understood entities comprised most of their list. However, a point which the authors emphasized was that most patients with fever of unknown origin do not have rare diseases, but rather have unusual or atypical manifestations of common diseases.

"After patients have had a conventional hospital work-up for a fever of unknown origin, including cultures, x-rays, serologic tests, skin tests, *et al.,* and if the patient has had fever of at least three weeks' documented duration, and exceeding 101 degrees orally on several occasions, the authors felt that the patient could rightfully be classified as having FUO. If these conditions were met, the next step should be biopsy of any suspicious localized lesions, visible externally or by x-ray, with microscopic examination and culture of the material obtained. If such a lesion were detected on initial investigation of the patient and were easily accessible to the surgeon, such as a skin lesion or lymph node, it should be biopsied before other extensive examinations were undertaken, provided the FUO was duly documented (Sutton's law).

"In the absence of an obvious suspicious lesion, the authors felt that needle biopsy of the liver, with culture of the material obtained, was probably the next step of choice. They also emphasized that exploratory laparotomy was justified as a final resort, and in many cases yielded not only a diagnosis but a treatable disease process. In addition, a large percentage of their cases was eventually diagnosed simply by careful and thoughtful review of the data in the history, physical findings, and laboratory work, as Dr. Shaw has exemplified for us."

Question: "Was sputum cytology done?"

Dr. Wilson: "No; that was about the only stone left unturned." ★★★

1190 North State St. (39201)

REFERENCE

1. Petersdorf, R. G., and Beeson, P. B.: Fever of Unexplained Origin: Report on 100 Cases, Medicine 40:1, 1961.

OBSCENE PROPOSAL

The distraught young woman confided in her best friend: "I have broken my engagement to Jim, because he continually uses dirty four-letter words."

"This is shocking and hard to believe," replied her companion. "I have always known Jim as a man of high character and excellent reputation."

"But he does use dirty four-letter words," sobbed the first, "like 'cook,' 'wash,' and 'iron!' "

Radiologic Seminar LXXXI: Abdominal Pregnancy

CLIFTON L. HESTER, JR., M.D.
Jackson, Mississippi

A 21-YEAR-OLD Negro female presented with a history of no menses for over seven months and left lower and bilateral upper abdominal pain for approximately two weeks. This had become worse, and she was thought to be in labor. Physical examination on admission revealed a mass arising out of the pelvis, measuring 24 cm. in diameter. Fetal heart tones were heard in the left lower abdomen, and the vertex was felt bulging in the posterior fornex. The external os was dilated 3 cm, the internal os was closed, and the cervix was thought to be displaced anteriorly.

Fetograms were obtained (Figures 1 and 2) and on these it was noted that maternal intestinal gas was intermingled with fetal parts. The fetal parts were unusually extended and "spread out" within the maternal abdomen with parts of the fetus overlapping the maternal spine in the lateral projection. A uterine outline around the fetus could not be identified.

To further substantiate the probable diagnosis of extrauterine pregnancy, a soft rubber catheter was inserted through the internal os. Ethiodol was introduced, outlining a slightly enlarged, anteriorly displaced uterine cavity separated from the fetus.

A laparotomy was performed, and a 7 pound, 6 oz. viable infant was delivered from the abdominal cavity. The placenta was attached to the left broad ligament, left ovary, and several loops of small bowel.

Suggestive radiographic signs of extrauterine or abdominal pregnancy on plain films in order of importance are:

1. Demonstration of the uterine shadow separate from the fetus. This is rare but is the most diagnostic sign on plain films.
2. Abnormal position and presentation of the fetus. (Often unusually high and transverse.)
3. Demonstration of fetal parts overlapping the maternal spine in the lateral view.
4. Intermingling of maternal intestinal gas shadows with the fetal parts.
5. Unusual clarity of the fetal parts.
6. Non-visualization of the uterine shadow surrounding the fetus.
7. Unchanging position of the fetus on serial studies.
8. Unusually close proximity of the fetus to the maternal anterior abdominal wall.
9. The fetal parts unusually extended or "spread out" within the maternal abdomen.
10. Occasional calcification of the amniotic sac.

In most cases at least five of these suggestive signs can be identified on the fetogram.

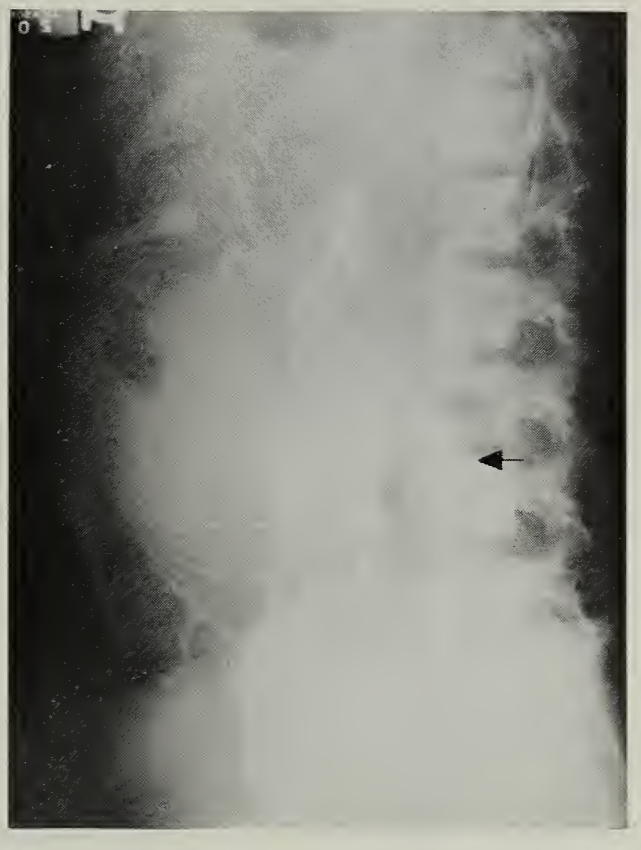
Usually a definitive diagnosis is not possible from plain films alone and a hysterogram can be obtained to substantiate the diagnosis. This procedure should be performed only when there is clinical suspicion and several of the suggestive radiographic findings are noted on the fetogram.

The principal clinical entity to be differentiated is the presence of a ruptured uterus. Here an enlarged uterus is found and usually signs of peritoneal fluid are seen. Occasionally, free air may be found in the peritoneal cavity. The diagnosis of ruptured uterus is usually made on the basis of clinical findings alone. ★★★

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi School of Medicine.

2500 North State St. (39216)





Figures 1 and 2. AP and lateral views of abdomen. Note partial extension of extremities with "spread out" appearance of fetus. There is overlap of fetal parts over the maternal spine on the lateral view (see arrow).

VIVE LA DIFFERENCE

The five year old son of a Methodist minister and the little daughter of a neighboring family were playing together. Deciding to wade in the lake, they agreed that the only way to keep their clothes dry was to take them off.

As they entered the water, the little boy happened to look at his female companion. "Gosh," he exclaimed in wonder, "I didn't know that there was *that* much difference between Catholics and Protestants!"



The President Speaking

'A Two-way Street'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE RESTRICTIVE AND SEVERE moves by the Social Security Administration on permissible charges under Part 1-B of Medicare will leave many physicians perplexed and wondering. For a vast majority, the program has posed no problem in meeting usual and customary charges made in the care of beneficiaries. So where a physician has been fair and proper in his dealings with his Part 1-B carrier, he now finds himself at the disadvantage.

The restrictions on fees could be damaging to some physicians, especially if they had contemplated adjustments in charges based on examination of their 1968 books by their respective auditors. Perhaps many among these have been earnestly endeavoring to avoid, if at all possible, any fee adjustments. Now, for whatever reason, they are faced with almost insuperable justification requirements.

Any program for financing medical care, private or governmental, in order to continue to be successful, must take into consideration the continuing pressures of inflation and the upward spiral of the costs of living. Within the month, employers face another mandatory increase under the federal minimum wage law. The 10 per cent surtax on existing income taxes continues after initiation in 1968. The picture is clear, and there are no dark secrets about the costs of medical care and what constitutes the components of this cost. It is probably one of the most thoroughly-analyzed, often-studied, and most written-about subjects.

This growing problem demands urgent and decisive action, precise identification, and early solution. American medicine recognizes and cheerfully accepts its grave responsibilities, and in so doing, it has every right to full consideration by a government rapidly moving to price a professional service which it does not have to sell. ★★★

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EDITORIALS

The Growing Crisis in Professional Liability Insurance

I

"When you need more, it's not for sale, and what you have is both necessary and costly." This taut observation could apply only to professional liability insurance, and the trend in premium costs is rapidly moving toward a crisis in the United States. It is the highest priced casualty line insurance which a physician ordinarily purchases, and in this era of suits and litigation, it is vitally necessary to him.

In the past two years, rates for professional liability insurance have advanced as much as two-fold in some states. More alarming, a number of insurance companies are withdrawing from the field. A small line of coverage, the sum total of all the professional liability contracts for American physicians hardly exceeds the total of automobile collision policies in Atlanta, Ga. Hence, it is called an "accommodation line" by the insurance companies, because there is low volume.

In every quarter, there are signs pointing to the necessity of medical organization becoming more interested in this essential coverage for its members. It is not enough to have a committee merely review rate structures or conduct infrequent meetings with representatives of the insurance industry. More and more state medical associations are realizing just how important it is to establish and maintain review mechanisms which continually monitor every aspect of this indispensable protection. In Mississippi, this has been the rule for many years with the association's governing body, the Board of Trustees, making professional liability insurance a command subject.

II

Since 1961, the state medical association has sponsored a professional liability insurance program with the St. Paul Companies as the underwriters. Four out of 10 members of the association carry contracts with St. Paul. The association maintains week-to-week communication with company representatives and regularly receives detailed reports on the program.

This is not an insurance group in the textbook sense, because each contract is individually written, and the assured physician is served by the company as an individual. The volume of business, however, is such that the company can provide special coordinating and liaison services.

The association, in conducting this program with the St. Paul Companies neither excludes nor ignores similar underwriting services from the many other reputable carriers. Obviously, six out

of 10 members either purchase professional liability insurance with such other companies or have none at all. As a matter of fact, the association looks upon all reputable companies providing this coverage with respect and desires most earnestly to extend full and complete cooperation to them in serving the membership.

III

The carefully monitored and closely coordinated program which shall have been in effect eight years next July has proved beneficial to Mississippi physicians. Since 1961, premium rates have been reduced by one-half, and today, Mississippi has the lowest professional liability insurance premium in the nation. It's one time we are delighted to be last.

There have been rate adjustments, to be sure, especially during the past two years. The five-part classification system, ranging from those who do no surgery in Class I through the so-called higher risk category in Class V, has been primarily responsible for these adjustments. Thus, some physicians have experienced, in fact, a rate increase with reclassification of their specialty. An example of this was reclassification of anesthesiologists to Class V.

There is now an impending change on "excess limits" cost determination. The factor by which the base premium for $5,000/$15,000 coverage is multiplied has been increased by 25 per cent in every state. This has the effect of a premium increase, although it is literally not. In many states, premiums have been upped, and the increase in the excess limits factor pushes the price even higher.

IV

It is fundamental and axiomatic that insurance costs what the risks and losses make it cost. On occasion, there is the thoughtless allegation that the insurance companies charge high rates on essential coverages, enjoying, for all intent and purpose, the benefits and profits of a captive market. Nothing could be farther from the truth.

No business in the United States is more closely regulated than casualty line insurance. While it is also true that interstate (transportation) carriers, public utilities, and banks are similarly regulated as to what they may charge for their services or products, it should be remembered that legal reserves are required of insurance companies. Thus, it might be noted that no railroad is required to establish its solvency by actual deposit of funds in a state where it operates.

Each insurance company licensed to conduct business in Mississippi must file its rates with the Commissioner of Insurance on each and every contract it issues. Any changes in these rates—either up or down—must be approved by the commissioner who keeps careful tab on each company's operating record and its financial condition.

The association has approached the problem of professional liability coverage with reasoned interest and a full appreciation of its importance. With the growing crisis, other state medical associations will find such a program vital to their members.—R.B.K.

Sen. Javitts and the Issue of Malnutrition

During the celebrated "hunger hearings" last year by a Senate committee headed by Sen. Joseph Clark (D., Pa.), since defeated for re-election, at which representatives of the Mississippi State Medical Association appeared as witnesses, one of the most bellicose inquisitors of the southerners was Sen. Jacob Javitts (R., N. Y.). He lashed out at the government and medical profession of Mississippi with a fervor difficult to describe.

Nor was Sen. Javitts in the least ruffled when then-Secretary of Agriculture Orville Freeman testified that Mississippi was the only state (at that time) in the nation with a food program, either surplus commodities or food stamps, operative in every county. The senator laid it on about the starving thousands in Mississippi.

Health News, the official publication of the New York State Department of Health, in the issue for Dec. 1968, reports a survey in 20 upstate New York counties "to determine the prevalence and location of severe malnutrition and related health problems." The publication reports that "a similar survey is being done in New York City by the City Health Department." All in all, it sounds as if Sen. Javitts' proposals for Mississippi are being implemented in his home state.

This isn't an expression of we-told-you-so or of the pot calling the kettle black. Wherever it may be discovered, malnutrition is a tragic as well as a serious and urgent problem. Every thinking and fair American would exert a maximum effort to wipe out hunger in this land of plenty. It is just as distressing to see a hungry child in Chautauqua County, N. Y., as one in Mississippi.

The whole mess is compounded when political capital is made of a circumstance elsewhere when

the tragic problem exists back home. Let's expend these energies in eliminating the problem instead of laying it at someone else's door.—R.B.K.

1799 and the State of the Science

The first President of the United States died two years after retiring from office. The terminal condition was pneumonia and while everything possible was done for—or in the light of today's state of the science, to—General George Washington, a review of the report of the two physicians in attendance leaves no doubt as to what the outcome would be.

On Dec. 12, 1799, General Washington had been exposed to rain and cold. On the following day, he became ill with what the doctors later described as "an inflamatory affection of the upper part of the windpipe." Drs. Elisha C. Dick and James Craik wrote that "the disease commenced with a violent ague and a difficult, rather than painful, reglutination, which were soon succeeded by a quick and laborious respiration."

The necessity of blood-letting was suggested to the General, and between 12 and 14 ounces were taken from his arm on the night of Dec. 13. The next day, Drs. Dick and Craik arrived and began copious bleedings. Blisters were applied to the affected parts, they wrote, and two moderate doses of calomel were given. The physicians were distressed to report that the respiration became still more difficult.

Another 32 ounces of blood were drawn "without the smallest apparent alleviation of the disease." Additional therapeutic measures included administration of 10 grains of calomel, succeeded by repeated doses of tartar, amounting in all to five or six grains, Drs. Dick and Craik said. The General was also given "various vapours of vinegar" which were frequently inhaled. The consultants noted grimly that the treatment had "no other effect than a copious discharge from the bowels."

The report concluded that "the powers of life seemed now manifestly yielding to the forces of disorder, and blisters were applied to the extremities, together with a cataplasm of bran and vinegar to the throat. Speaking was painful from the beginning and now became almost impractical; respiration became more contracted and imperfect, till at last, on Saturday night, retaining full possession of his intellects, he expired without a struggle."

Some hours before death, General Washington "succeeded in expressing a desire that he be allowed to die without further interruption." The point of the pitiable narrative is the astonishing forward thrust of medical science during the intervening 169 years and just how primitive today's care may seem in the year 2138.—R.B.K.

Sauce Béarnaise and Tomato Catsup

The 37th President of the United States is in the White House, and at the other end of Pennsylvania Ave., the 91st Congress is almost a month into its first session. These two theoretically independent branches of government are critically important to American medicine.

During the heated campaigns of 1968, there was a popular notion abroad in the land that the 91st Congress would bear little more resemblance to its predecessor than sauce *Béarnaise* does to red tomato catsup. But there was only a slight shift in the House of Representatives where the swing is 26 votes for majority defeat along party lines. There are now 243 Democrats and 192 Republicans.

The political fulcrum is nearer center in the Senate where a mere eight votes preserve the will of the majority party with 58 Democrats and 42 Republicans. The presence of Vice President Agnew thins the majority by one with his tie-breaking prerogative which for reasons of party can hardly be considered conjectural.

That a number of state medical association political action committees are already licking their chops over prospects in 1970 should come as a surprise to nobody, because then, 25 Democratic senators and only eight Republicans will be up for re-election. For the duration of the 91st Congress, conservatives may do well to be optimistic instead of gleeful, because the Democratic caucus and its Republican counterpart reconfirmed their respective liberal inclinations in the selection of new assistant majority leaders.

The nation has yet to digest—let alone pay for—the massive social and health enactments of the last four Congresses of the Kennedy-Johnson years. With no real solution to Viet Nam in sight, it's odds-on that the 91st Congress, taking practical note of the stagggering war costs and the occupant of 1600 Pennsylvania Ave., will be a little less enthusiastic about another Medicare or comparable program.

And until 1970, many physicians will be studying the recipe for sauce *Béarnaise* and paying their PAC dues.—R.B.K.

Mississippi M.D.'s Heed Dr. Ochsner

"Each cigarette a person smokes takes 14.4 minutes away from his life." So warned Dr. Alton Ochsner of New Orleans in a lecture series recently at Mississippi State University and Mississippi State College for Women.

The noted surgeon called smokers "the most selfish persons I know," because the motives for the lethal habit are his own, showing just how little he cares for those around him. Dr. Ochsner said that if one must kill himself, get a gun, because a bullet is quicker and cheaper than lung cancer.

He cautioned that pipes and cigars are also dangerous and that all tobacco usage can result in cancer, emphysema, other upper respiratory diseases, heart conditions, and ulcers. It even upsets the reproductive processes, he pointed out, stating that women who are heavy smokers have the greatest numbers of premature births.

There is ample evidence to demonstrate that an overwhelming majority of physicians agree with Dr. Ochsner, and the medical profession in Mississippi proves the case. At the recent 100th Annual Session at Jackson, a perceptive news reporter who had covered MSMA meetings for a decade wrote that there was a time "when you couldn't see the speaker in the Scientific Assembly for the cigarette smoke."

At the 1968 conclave, the reporter, covering the live color TV presentations which at one session were playing to a packed house, wrote that "there were only three people in the room smoking." While the consumption of tobacco remains high, the response of the medical profession must surely be encouraging to those with zeal and devotion in discouraging smoking.—R.B.K.

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

BRADFORD, WILLIAM MEREDITH, Jackson. Born Jackson, Miss., July 13, 1935; M.D., University

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Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

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Upon adverse reaction, stop medication and treat appropriately.

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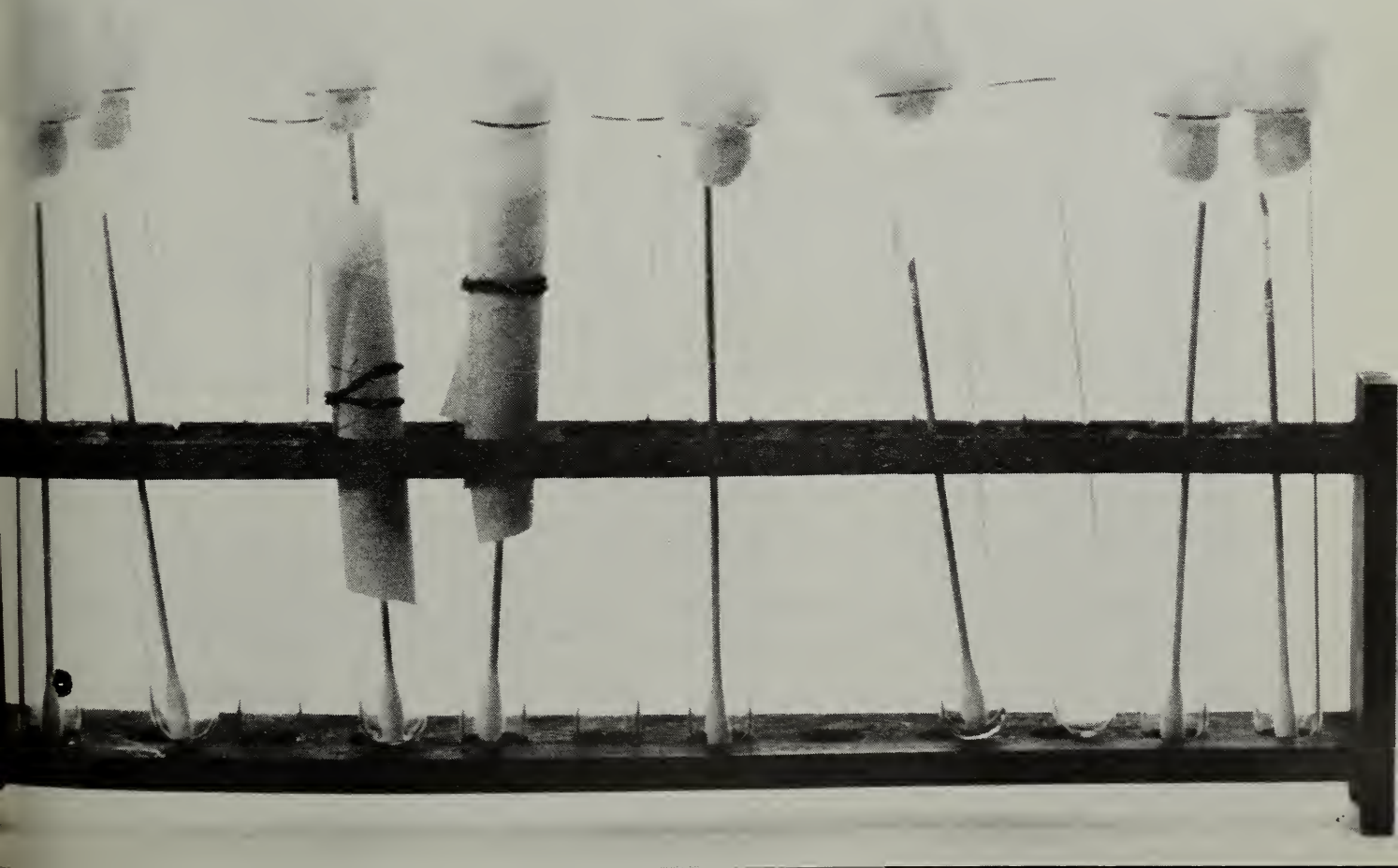
Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

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of Miss. School of Medicine, Jackson, 1960; interned University of Colo. School of Medicine, Denver, one year; urology residency University Medical Center, Jackson, Miss., July 25, 1964-July 24, 1968; elected Dec. 3, 1968 by Central Medical Society.

DERAPS, GORDON DOUGLAS, Jackson. Born Biddeford, Maine, Jan. 30, 1934; M.D., University of Texas Medical Branch, Galveston, 1959; interned Santa Rosa Hospital, San Antonio, Texas, one year; medicine residency, University Medical Center, Jackson, Miss., July 1, 1959-June 30, 1960; fellowship, same, July 1, 1964-June 30, 1967; elected Dec. 3, 1968 by Central Medical Society.

DOSTER, JAMES THOMAS, Columbus. Born Gadsden, Ala., July 27, 1937; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned Charity Hospital, New Orleans, one year; obstetric and gynecology residency, Baylor University, Houston, Texas, July 1, 1963-June 30, 1966; elected Dec. 10, 1968 by Prairie Medical Society.

KIRK, ANDY ELLZEY, Jackson. Born Doddsville, Miss., Oct. 8, 1939; M.D., University of Miss. School of Medicine, Jackson, 1964; interned Mobile General Hospital, Mobile, Ala., one year; residency, Naval Aerospace Medical Institute, Pensacola, Fla., Jan. 3, 1966-June 23, 1966; elected Dec. 10, 1968 by Prairie Medical Society.

LADNER, GEORGE DALE, Jackson. Born Biloxi, Miss., Feb. 22, 1936; M.D., University of Miss. School of Medicine, Jackson, 1962; interned Wilford Hall Hospital, Lackland AFB, Texas, one year; psychiatry residency, University Medical Center, Jackson, Miss., July 1, 1965-June 30, 1968; elected Dec. 3, 1968 by Central Medical Society.

WALLER, THOMAS EUSTACE, Starkville. Born Greenwood, Miss., Feb. 7, 1940; M.D., University of Miss. School of Medicine, Jackson, 1964; interned Miss. Baptist Hospital, Jackson, one year; elected Dec. 10, 1968 by Prairie Medical Society.

POSTGRADUATE CALENDAR

SYMPOSIUM ON HUMAN SEXUAL BEHAVIOR

Hotel Heidelberg, Jackson
February 19, 1969, beginning at 9:00 a.m.
Sponsored by the University of Mississippi School of Medicine and Mississippi Academy of General Practice, with the cooperation of Lederle Laboratories

Participants:

William O. Barnett, M.D., professor of surgery, chairman, Postgraduate Education Committee, The University of Mississippi School of Medicine

Donald J. Holmes, M.D., associate professor of psychiatry, University of Michigan Medical School, Ann Arbor

James P. Semmens, M.D., Captain, MC, U. S. Navy, chief, obstetrics and gynecology, Naval Hospital, Oakland, California

Joseph B. Trainer, M.D., associate professor of physiology and medicine, University of Oregon School of Medicine, Portland

Wednesday morning

THE PSYCHO-PHYSIOLOGIC DYNAMICS OF SEX
Dr. Trainer

FEMALE ADOLESCENT GROWTH AND DEVELOPMENT WITH ITS EMOTIONAL IMPLICATIONS
Dr. Semmens

SEX EDUCATION FOR PHYSICIANS, I
Dr. Holmes

POSTGRADUATE EDUCATION: THE MISSISSIPPI PHYSICIAN AND THE FUTURE
Dr. Barnett

Wednesday afternoon

SEX EDUCATION FOR PHYSICIANS, II
Dr. Holmes

SPECIAL CONSIDERATIONS IN TEEN SEX COUNSELING
Dr. Semmens

SEXUAL INCOMPATIBILITIES IN MARRIAGE
Dr. Trainer

PANEL DISCUSSION, QUESTIONS AND ANSWERS
All Speakers

CIRCUIT COURSES

Physicians in the Natchez area will host their second postgraduate education circuit course February 18. Topic for the 7:00 p.m.

meeting at Jefferson Davis Memorial Hospital is renal transplantation

EASTERN CIRCUIT
COLUMBUS—Session 2—February 25
Aubrey and Ellon's Restaurant, 6:30 p.m.
Renal Transplantation
Dr. John Bower
Dr. Hilary Timmins

EAST CENTRAL CIRCUIT
MERIDIAN—Session 1—March 4
Northwood Country Club, 6:30 p.m.
Total Esophageal Replacement, Dr. William A. Neely
Management of Malignant Melanoma, Dr. Heber Ethridge

FUTURE CALENDAR

February 18
CIRCUIT COURSE, NATCHEZ

February 19
SYMPOSIUM ON HUMAN SEXUAL BEHAVIOR

February 25
CIRCUIT COURSE, COLUMBUS

March 4
CIRCUIT COURSE, MERIDIAN

March 7
KIDNEY SEMINAR

March 17-21
STROKES AND RELATED NEUROLOGICAL DISEASES

March 26-28
CARDIOVASCULAR SEMINAR

April 1
CIRCUIT COURSE, MERIDIAN

April 15
CIRCUIT COURSE, COLUMBUS

April 22
CIRCUIT COURSE, COLUMBUS

May 6
CIRCUIT COURSE, MERIDIAN

May 12-15
MISSISSIPPI STATE MEDICAL ASSOCIATION

PERSONALS

C. MIMS EDWARDS of Jackson has announced an office schedule on Mondays and Tuesdays at the Messina Clinic, 1411 Cherry St., Vicksburg. Dr. Edwards limits his practice to Psychiatry and will continue to operate his office in Jackson. He will be in Vicksburg from noon Mondays through noon Tuesdays.

LYNN D. ABERNETHY of Jackson has been elected a member of the board of directors of the National Society for the Prevention of Blindness.

VAN DYKE HAGAMAN of Jackson is serving as chairman of the Mississippi advisory committee and as a voting member of the National Society. Both physicians limit their practice to ophthalmology.

THOMAS M. BLAKE of Jackson recently appeared as principal speaker at the District 1 meeting of the Mississippi Heart Association at Natchez. The meeting included making of plans for the annual Heart Fund campaign in a five county area.

WILLIAM P. BOBO of Clarksdale conducted a course at the Coahoma General Hospital last month in cardiopulmonary resuscitation. He received training for the task during a 1968 UMC-Mississippi Heart Association seminar. The Clarksdale course was attended by physicians and allied professional personnel.

RICHARD G. BURMAN of Gulfport has been elected to the 10-member medical advisory committee of the American Association of Medical Assistants.

C. RALPH DANIEL, SAMUEL B. JOHNSON, and S. H. MCDONNIEAL of Jackson were recently at Cody, Wyo., for a big game hunting trip in the Thorofare Area near Yellowstone National Park. The game bag was a 6-point elk for Dr. McDonnieal and a 4-point elk and a 4-point mule deer for Dr. Johnson. Dr. Daniel was reported to have refused shots at elk because of smaller size than he had previously bagged. The trip was made in Dr. Johnson's plane.

JOHN E. EVANS has become associated with the Parsons, Whitaker, and Neill Clinic at Vicksburg where he will limit his practice to orthopaedic surgery.

RAYMOND F. GRENFELL of Jackson was the principal speaker at the recent District 14 meeting of

the Mississippi Heart Association at Tupelo. The district includes Alcorn, Itawamba, Lee, and Prentiss counties. In addition to his work with the heart association, Dr. Grenfell serves as chairman of the state medical association's Committee on AMA-ERF.

MARVIN V. HARVEY has established offices in the Beacham Memorial Hospital at Magnolia where he will practice general surgery. He received his medical certificate from Ole Miss and his M.D. from the University of Tennessee College of Medicine. After experience in general practice, he received four years of training in general surgery at the Baptist Hospital and University of Tennessee at Memphis.

JESSE L. HENDERSON of Natchez has announced the removal of his offices to 453 John R. Junkin Drive where he limits his practice to orthopaedic surgery.

W. L. JAQUITH of Whitfield, director of the Mississippi State Hospital, recently lectured at the University of Mississippi Oxford campus on "Abnormal Behavior and Drug Abuse." The lecture was sponsored by the University's law enforcement training program.

HERMAN E. KELLUM, JR., of Vicksburg has been appointed a member of the board of directors of the Vicksburg Hospital and Vicksburg Clinic. He serves as chief of the clinic's department of surgery. He is a medical graduate of the University of Tennessee College of Medicine and has been associated with the clinic for six years.

ROY C. MCGLAMERY of Ripley is assuming charge of the 100-bed Baptist Hospital in the Gaza Strip on Feb. 1. He will be accompanied by Mrs. McGlamery who will work with the Baptist church in the Middle East. Both Dr. and Mrs. McGlamery are members of the Baptist Foreign Mission Board and have previous service as missionaries with eight years in Colombia.

PATRICK G. MCLAIN of Vicksburg has announced the removal of his offices to 1513 Clay St. where he continues to limit his practice to ophthalmology.

HOWARD H. NICHOLS of Jackson has been appointed Head Start Consultant for the state of Mississippi by the American Academy of Pediatrics. He is also serving as the pediatrics member of the advisory committee to the study on health information systems being conducted by the association for the state of Mississippi.

JO NEWELL ROBINSON is serving as president of the Columbus Music Association. The civic service group has just concluded its 1969 membership drive and is now seeking patrons for the new season.

EDSEL F. STEWART of McComb has been certified as a diplomate of the American Board of Obstetrics and Gynecology. He received his medical degree from the University of Virginia and his specialty training at the New Orleans Charity Hospital on the Tulane service.

JACK A. STOKES of Pontotoc, 1968-69 vice president of the state medical association, has been inaugurated president of the Northeast Mississippi Medical Society. Mrs. Stokes is president-elect of the Woman's Auxiliary of the society, and she will take office in March.

DAVID J. VANLANDINGHAM of Jackson, acting in behalf of the First Baptist Church in which he serves as a deacon, presented Eagle Scout badges to four Boy Scouts in the church-sponsored troop.

WALTER D. VICK has announced the removal of his offices from Greenville to Grenada. He received his premedical education at Mississippi State University and his medical degree at the University of Tennessee College of Medicine. He was in practice for six years in general medicine before taking his residency in obstetrics and gynecology at the St. Francis, the Queens, and the Kapiolani hospitals in Honolulu.

DAYTON E. WHITES of Lucedale has been sworn into office as a member of the George County School Board. He was elected in the Nov. 1968 general elections.

DEATHS

REMBERT, GEORGE WILLIAM FRANCIS, Jackson. M.D., Tulane University School of Medicine, New Orleans, La., 1903; interned Touro Infirmary, New Orleans, one year; postgraduate work, Vienna, Austria; Heidelberg, Germany; Harvard University, and University of Penn.; Emeritus member of Mississippi State Medical Association; member MSMA Fifty Year Club; died Jan. 2, 1969, aged 89.

Sky High Professional Liability Premiums Shake Profession; Mississippi Is Lowest

Zooming premium rates for professional liability insurance are hitting new record highs with insurances sources reporting some degree of rate increases in a vast majority of states. Mississippi now ranks 50th with the lowest premium rate in the nation.

Dr. C. D. Taylor, Jr., of Pass Christian, chairman of the Board of Trustees, said that "this critical matter has been a major item for continuing attention by the Board, and this effort has paid off both in service to association members and in a lowering premium."

He said that the Board conducted an extensive review of the crisis in professional liability insurance costs at its recent winter meeting, noting with satisfaction that since 1961, premium rates for the essential coverage in Mississippi had declined by 50 per cent.

"In most states," Dr. Taylor said, "rates have been going up rapidly during the same time."

Rates announced by the Insurance Rating Board, formerly the National Bureau of Casualty Underwriters, the trade association which keeps tab on losses and suggests rate adjustments, show that a physician in California who performs general surgery is now paying over $2,000 premium annually for 100/300 coverage.

Basic rates, computed for $5,000/$15,000, range nationally from a low of $115 in Mississippi for a Class V surgeon to a high of $925 in California. Rates in states bordering Mississippi range from a third higher to almost twice in cost.

To compute additional premium charges for 100/300, the basic rate is multiplied by 2.58, a coefficient known as the excess limits factor. The coefficient was recently raised to 2.58 from 2.06 in every state.

Compounding costs difficulties are the with-

Professional Liability Premiums, $5,000/$15,000 Basic Coverage

Alabama	$205	Kentucky	$205	N. Dakota	$180
Alaska	275	Louisiana	250	Ohio	340
Arizona	610	Maine	200	Oklahoma	330
Arkansas	185	Maryland	280	Oregon	395
California	925	Massachusetts	240	Pennsylvania	245
Colorado	420	Michigan	295	Rhode Island	185
Connecticut	240	Minnesota	212	S. Carolina	125
Delaware	140	Mississippi	115	S. Dakota	175
D. C.	365	Missouri	255	Tennessee	175
Florida	345	Montana	405	Texas	200
Georgia	255	Nebraska	145	Utah	305
Hawaii	370	Nevada	610	Vermont	190
Idaho	285	New Hampshire	125	Virginia	170
Illinois	235	New Jersey	520	Washington	325
Indiana	260	New Mexico	435	W. Virginia	190
Iowa	310	New York	600	Wisconsin	270
Kansas	215	N. Carolina	130	Wyoming	125

Rates shown are for Class V surgeons, single coverage for basic limits, as of Nov. 30, 1968. Source: IRB.

drawal of some companies from the professional liability market, the Board of Trustees has discovered. In California with the highest ratio of professional liability suits, only two insurance companies are now writing the coverage, according to AMA sources.

Generally, premium rates tend to be lower in the south and show increases toward the west. The West Coast states are highest, but New York and New Jersey are also high. Urban centers alone apparently do not account for rate structures, since Illinois is only slightly higher than Tennessee, even with Chicago in the former.

Dr. Taylor said that the Board of Trustees continues to monitor the rate structure and offer advisory services to members in event of threatened or actually instituted litigation.

"We encourage any member who is threatened with a suit or against whom a suit has been filed to inform his Trustee immediately. Arrangements will be made from necessary conferences with the physician's attorney, and the entire matter will be reviewed by the Board of Trustees in executive session," Dr. Taylor said.

"There is, of course, nothing mandatory about this procedure," he added, "and failure by a member to seek these advisory services which are his to command results in no stigma upon him, nor does it foreclose the possibility of his being able to call on the Board later in this same connection."

Advisory services by the Board, long experienced in this type of counsel, may include recommendations to contest the suit or even to seek or accept settlement offers. Often, the Trustees make useful suggestions as to expert witnesses.

A member may choose his own course of action, Dr. Taylor stressed, whatever the recommendations he may receive.

Insurance executives have stated to the association that the nationwide low premium rate in Mississippi largely results from the careful program management by the Board of Trustees and cooperation by members. The Board recommends that all members carry sufficient limits of protection in professional liability insurance and consider carefully the added protection of umbrella coverage.

Parchman Seeks Full-time Physician

The state medical association has pledged its efforts to assist the state of Mississippi in securing a full-time physician for the Parchman State Penitentiary. Action came at the recent winter meeting of the Board of Trustees.

Drs. James L. Royals, president-elect, and William E. Lotterhos, speaker of the House of Delegates, both of Jackson, are serving as a committee to work with Gov. John Bell Williams. They have conferred with the governor and have made an on-site inspection of the medical facilities at the penitentiary with him.

Also making the inspection trip were Drs. Robert E. Blount of Jackson, UMC dean and assistant dean, respectively, and Herman Glazier of Jackson, executive assistant to Gov. Williams.

Under a revised appropriation for the institution, Gov. Williams said that a salary of $25,000 per year would be paid to a full-time physician. Additionally, a home will be furnished with two servants as a further benefit. Farm produce and other foodstuffs will also be provided.

Drs. Royals and Lotterhos said that meetings have also been conducted with Dr. Robert E. Carter and Dr. Robert E. Blount, the dean and assistant dean, respectively, of the University Medical Center, on arranging UMC affiliation with the Parchman service. Funds are available for extending training programs to the institution, Drs. Royals and Lotterhos reported.

The association's Physician Placement Service is making a major effort to locate a physician for the position, and communication with other major placement services is underway.

Interested physicians are urged to communicate with the state medical association.

Health Planning Courses Are Offered at UMC

The first of a series of unique short courses in area health planning has been conducted at the University of Mississippi Medical Center in Jackson. The programs, a first for the state, are made possible through a United States Public Health Service grant.

Lectures, discussions, study of reference materials, and laboratory practice in health planning

comprise the curriculum, planned for those with responsibility or particular interest in providing community health services. Each short course will include six sessions to be held on Friday and Saturday of three consecutive weeks. Attendance is limited to 15.

Dr. James B. Moore, director of the office of Allied Health professions, University Medical Center, is course coordinator.

The course will be repeated at an as yet unscheduled date in the spring.

RMP Offers Intensive Course on Stroke

Participants in the first refresher course on Stroke and Related Neurological Diseases offered at the University Medical Center in Jackson took part in five full days of formal lectures, conferences, rounds, and patient care in the clinics and the stroke unit at the University Hospital.

Registrants and neurology faculty at a concluding conference were Dr. Ralph Brock of McComb, Dr. Irvin Cronin of Jackson, Dr. Robert D. Currier, professor of medicine, Dr. Armin Haerer, associate professor of medicine, Dr. Ray Stewart of Gulfport, Dr. John Atwood of Meridian, and Dr. Aubrey Harris of Tupelo.

Presented as a continuing education facet of the Mississippi Regional Medical Program stroke unit program, the course will again be offered in March for the benefit of physicians who could not be accommodated in the opening session. Registration is limited to five.

Noted Tennessee Medical Educator Dies

Dr. O. W. Hyman of Memphis, one of the nation's best known medical, dental, and allied sciences educator, died Nov. 9 after 48 years association with the University of Tennessee. He had been retired as vice president of the university and dean of the medical school since 1961.

Dr. Hyman came to U. T. as an instructor in histology in 1913 and was appointed business manager in 1922, the year after he had earned his Ph.D. at Princeton University. Trained as a zoologist, he had earned the B.S. and M.S. degrees at the University of North Carolina where he was tapped for Phi Beta Kappa.

In 1925, Dr. Hyman was named dean of the College of Medicine and administrative officer of the U. T. Medical Units. In 1948, he was elevated to vice president of the University. Since his retirement in 1961, he had remained active in academic affairs, and the University maintained a research laboratory for his use.



Participating in the intensive course on stroke and related neurological diseases at UMC are, from the left, Drs. Ralph Brock, Irvin Cronin, Robert D. Currier, Armin Haerer, Ray Stewart, John Atwood, and Aubery Harris. The week-long postgraduate project was under the Regional Medical Program.

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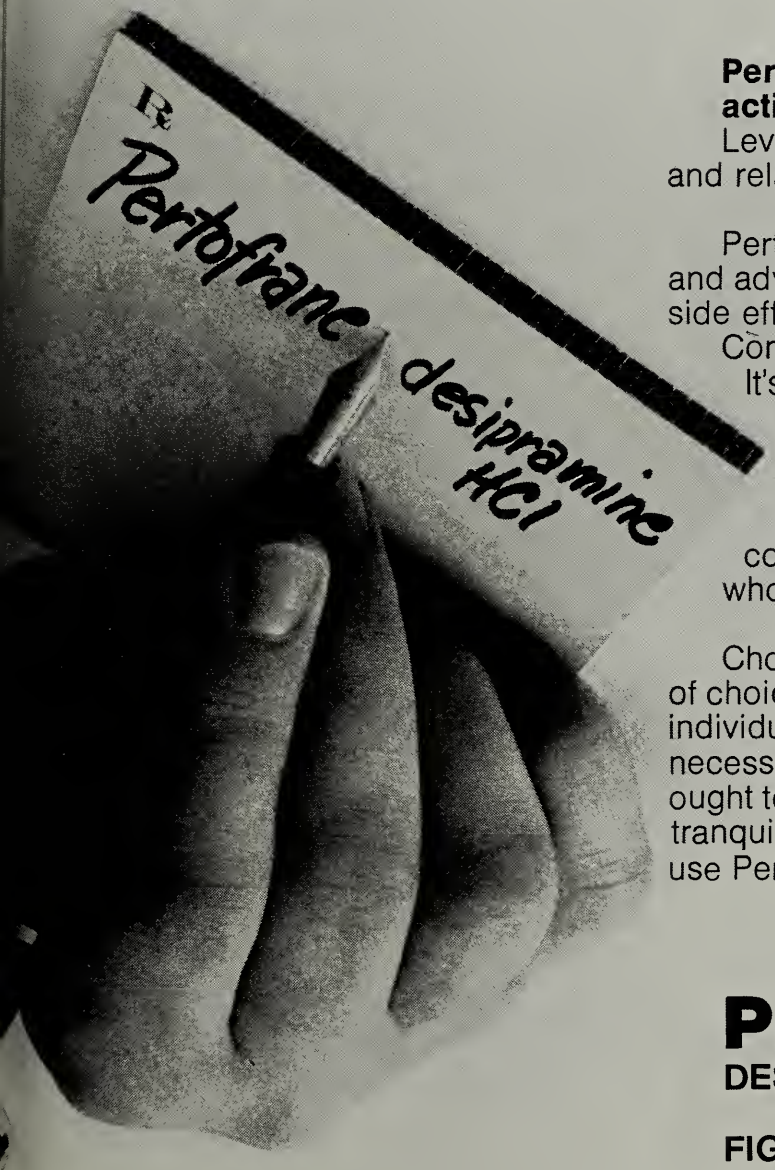
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FIGHTS DEPRESSION

Tuberculosis Prevention Is Stressed by SBH

A one-year-old prevention program in Mississippi represents "a new era in tuberculosis control," according to Dr. Durward Blakey, who heads the Preventable Disease Control Division of the Mississippi State Board of Health.

Dr. Blakey, reviewing the program launched in Jan. 1968 after five years of advance planning, calls it "our greatest hope in identifying persons susceptible to tuberculosis, so that we can administer preventive treatment."

Up until recently, says Dr. Blakey, the State Board of Health directed its tuberculosis-control program primarily toward finding overt cases. But in recent years, the emphasis has been shifting toward finding persons susceptible to tuberculosis.

Dr. Blakey defines susceptibles as those persons whose skin tests show that they have had contact with the tuberculosis organism.

The switch in emphasis is being made possible, he says, by twenty years' accumulation of information on tuberculosis patterns in the state, based upon case-finding by mobile X-ray units and upon daily routine work, including treatment, by State Board of Health personnel at local level.

"This experience," says Dr. Blakey, "has given us the necessary background knowledge with which we can now open a program of prevention. We hope that this program will enable us to raise generations free of contact with the tuberculosis bacillus."

The new program calls for increased emphasis on skin tests and X-rays, as well as the use of a drug called INH. This drug is described by Dr. Blakey as "the number one drug for the prevention and treatment of tuberculosis."

In 1968, the program identified over 8000 susceptibles. These people represent a cross section of those seen at the local health clinics. Each individual was placed under a one-year prevention program using INH. As their year ends in 1969, they will be taken from the program, and all indications are that most of them will have received protection from or resistance to tuberculosis.

"When we began the program in January of 1968," says Dr. Blakey, "we anticipated we might have to carry as many as 20,000 susceptibles at one time. We will, of course, drop some cases in 1969, but we will be adding others at a greater rate. We should level off, eventually, at about 15,000 cases."

The "daily grind" of tuberculosis-control work in the fifties and sixties is paying off today, says Dr. Blakey. The number of new cases of tuberculosis has dropped from 1906 in 1947 to 822 in 1957 to 733 in 1967. As of Nov. 1, 1968, it stood at 530.

This, says Dr. Blakey, is a result of "rounding up the case load," over the years, beginning in the late forties, when the State Board of Health started covering more territory faster by the use of mobile X-ray units which took the search for tuberculosis into the most remote areas.

"But the practical eradication of tuberculosis is still a tremendous distance away," says Dr. Blakey, "and the results of the new prevention program will not show up on our register for a few years yet."

The register to which Dr. Blakey refers is the annual count, by the State Board of Health, of those who have tuberculosis in any given year. The total has dropped from 5220 in 1956 to 4509 in 1966. The total for 1967 was 4294, and indications are that the 1968 figure will be still lower, although this total will not be available until mid-1969.

"While we are still a long way from conquering tuberculosis," says Dr. Blakey, "we believe that our new prevention program will help considerably in reducing the number of new cases."

Nominating Committee Sets 1969 Slate

The Nominating Committee of the state medical association met Jan. 23 to begin consideration of a slate on which delegates to the 101st Annual Session will act. The new procedure, approved at the 1968 meeting, will assure that all nominees for office in the association are known to the membership before the 1969 conclave convenes.

The death of one member and the retirement of another created two vacancies on the nine-member committee of the House of Delegates. Named by President Joseph B. Rogers to succeed the late Dr. E. LeRoy Wilkins of Clarksdale is Dr. John G. Egger of Drew. Dr. James T. Thompson of Moss Point was appointed to succeed Dr. B. B. O'Mara who has recently retired for health reasons.

Other members of the committee are Drs. James O. Gilmore of Oxford, Thomas W. Wesson of Tupelo, S. Lamar Bailey of Kosciusko, and J. A. K. Birchett of Vicksburg.

Also representing their respective districts are

Drs. Charles B. Mitchell, Jr., of Meridian, Charles R. Jenkins of Laurel, and W. Moncure Dabney of Crystal Springs.

Association spokesmen said that release of the slate of nominees is expected by April 1. The new provisions of the By-Laws requires that the report of the committee be published at least one month in advance of the annual session at which the elections are to be conducted.

UA Will Receive Statue of Hippocrates

A statue of Hippocrates, the "father of medicine," will grace the plaza of the new Alabama Medical Center academic buildings which are now under construction in Birmingham.

The statue, now being sculpted by Greek artist Kostas Georgakas, is a gift of Mr. and Mrs. Sam Nakos. Mr. Nakos is a Birmingham businessman and a native of Corfu, Greece. During the past summer, Mr. and Mrs. Nakos visited their former country and while there, saw the work of the sculptor, Georgakas. Satisfied of his exceptional talent, they decided to commission a heroic marble statue of the great physician for the Medical Center of the University of Alabama in Birmingham, as a commemoration of Greek contributions to medicine, and particularly those of Hippocrates.

The statue and pedestal, which are expected to be completed in about two years, will stand 14 feet high. It is being wrought from the same Greek marble from which the Parthenon was constructed. According to the sculptor, it will take an eight ton block of marble to produce the statue which will weigh approximately 2½ tons.

The idea of presenting the statue to the Medical Center was conceived last year, when Birmingham's Festival of Arts saluted Greece. Members of the city's Greek community were enthusiastic about the gift, and have since expressed great pleasure that their native country and the famous early physician will be "so handsomely represented in the Center."

"The statue will be not only a beautiful and appropriate addition to the Medical Center," said Dr. Joseph F. Volker, Executive Vice President of the University of Alabama in Birmingham and Director of the Medical Center, "but will be an impressive landmark and tourist attraction to the city of Birmingham. We are most grateful to Mr. and Mrs. Nakos for their gift." Dr. S. Richardson Hill, Jr. and Dr. Charles A. McCallum, Jr., Deans of the medical and dental schools, joined Dr. Volker in expressing appreciation. "The statue will be a true inspiration to our present students and to those of generations to come."

Dr. Gray's Portrait Is Unveiled at SBH

A portrait of the late Dr. Archie L. Gray was unveiled in ceremonies at the Mississippi State Board of Health. It will be displayed in the building housing the organization which Dr. Gray served for 38 years, the last 10 of which he was state health officer.

Dr. Hugh B. Cottrell, Dr. Gray's successor as state health officer, accepted the portrait and paid tribute to his colleague and his leadership "during one of the nation's most trying transitional periods in public health concepts and practices." Presiding over the unveiling ceremonies was Dr. Frank J. Morgan, Jr., assistant state health officer.



Drs. Hugh B. Cottrell and Frank J. Morgan, Jr., are shown with the oil portrait of the late Dr. Archie L. Gray.

Members of Dr. Gray's family also participated in the ceremonies, his daughter, Mrs. John Fenton of Atlanta, unveiling the portrait and another daughter, Mrs. Harry Allen of Long Beach, spoke for the family. The third daughter, Mrs. L. K. Ward of Tullahoma, Tenn., participated in the unveiling, and Mrs. Gray was prominent in the ceremonies honoring her late husband.

The portrait was commissioned by Dr. Gray's fellow workers in public health and purchased with voluntary contributions.

Modular Room Has Sterile Environment

A room-within-a-room, specifically designed to provide a germ-free environment for patients with cancer during intensive anti-tumor therapy, is being developed for the National Cancer Institute by Litton Industries' Applied Science Division in Minneapolis, Minnesota.

Technically called a laminar flow patient isolator, the unit will be of modular design to fit into almost any hospital room presently accommodating two or more beds. In a day's time a standard two-bed hospital room can be turned into a single-bed isolator care unit, according to Arnold Blomquist, the Applied Science Division's Director of Advanced Programs.

A $196,000 developmental contract was awarded to the division late in June 1968 by the National Cancer Institute, a component of the National Institutes of Health. The program is under the direction of William Z. Penland who is project officer for the National Cancer Institute and Dr. Seymour Perry, Associate Scientific Director for Clinical Trials, NCI. The first units will undergo clinical testing in the Chemotherapy Area of the National Cancer Institute beginning in June 1969.

Instrumental in the development of the room are Richard K. Olson, the Division's Director of Research and Development, who is project officer, and Kenneth Abel, assistant project officer.

Blomquist pointed out that the germ-free environment created within the room will not only make possible more intensive treatment of patients with cancer, but it will also be suited for treatment of individuals with extensive burns; patients who have received heart, kidney or other transplants; and still other patients who are at high risk to infection. The sterile environment provided by these units would be vital to their well-being, Blomquist said.

The room will also have an inherent capability for containing micro-organisms, if so desired, and thus could be used to isolate patients with communicable diseases.

Key to the germ-free environment is the laminar flow design in which air passes through the room in a straight line and in a single direction. Thus, the air in front of the patient at any given moment is continuously clean and on the move, although he is not aware of air in motion. All of the air in the room is completely filtered six times each minute, or once every 10 seconds.

Studies indicate, according to Blomquist, that the laminar flow design can reduce the number of airborne organisms from 4,000 per 1,000 cubic feet of air to one (1) per 1,000 cubic feet of air.

An earlier isolation method encloses the patient's bed in a plastic envelope which seals him off from contact with the air in the room.

Blomquist, referring to "human factors engineering," explains that the laminar flow method is less confining and should enable the patients to remain under intensive care for a longer time, even for months if necessary.

Basic to the room is a bank of high efficiency particle arrestors (HEPA) filters, forming one of the walls. Structures for other walls are being evaluated—some include windows, others are designed for pass-through and storage. Wall modules will be of various sizes, with standard fittings to facilitate adapting them to hospital rooms.

Also in the design evaluation stage is furniture for use within the room. Blomquist said it must be functional as well as psychologically acceptable, and must not disrupt the flow of air through the room.

The filter unit is designed to meet Air Force specifications, and will operate at 99.97 per cent down to 0.3 micron efficiencies, a range that includes the trapping of bacterial particles.

ACP Sets Meet for USAF Internists

Specialists in internal medicine serving in the United States Air Force will attend a scientific meeting of the American College of Physicians (ACP) in Biloxi, Feb. 6-8.

The session is one of 35 regional scientific-educational meetings the ACP sponsors during the academic year. Held throughout the United States and Canada, the meetings help the College's 14,300 members keep abreast of developments in the basic sciences and clinical medicine.

Special guest will be Dr. Rudolph H. Kampmeier, Nashville, Tenn., ACP Immediate Past President and professor of medicine emeritus at Vanderbilt University School of Medicine.

The meeting is under the general direction of Col. Robert B. W. Smith, MC, USAF, Washington, D. C., ACP Governor for the U. S. Air Force. Col. Smith is chairman of the department of medicine at the USAF Hospital, Andrews Air Force Base.

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Syntex Publishes Fourth Dermatology History

The fourth volume in the series, "Leaders in Dermatology," previewed recently, describes the life and works of James Clarke White, M.D. (1833-1916), America's first professor of dermatology, and the most influential man of his era in improving the medical school curriculum in the United States.

Complimentary copies of the White biography will be distributed this month to dermatologists by Syntex Laboratories of Palo Alto, Calif.

A first copy was presented to Dr. Stanley E. Huff, president of the American Academy of Dermatology, during the Academy's 27th annual meeting. Dr. White was the first president of the American Dermatological Society, a forerunner of the Academy. He served as president in 1876.

A brilliant lecturer and a strong advocate of clinical studies, Dr. White was one of the most prolific writers in the history of medicine. Between 1856 and 1913, he contributed 125 original articles, 50 reviews, 94 editorials and eight books. In 1887, he published perhaps his most famous book, *Dermatitis Venenata: An Account of the Action of External Irritants Upon the Skin.* It was the first complete book ever published on the subject.

Dr. White's more than 300 writings and lectures covered almost all of the cutaneous diseases, including Lupus vulgaris, Pityriasis versicolor, Scabies, Army Itch, Tinea trichophytina, Melanoderma, Leprosy, Pityriasis rubra pilaris and Prurigo.

Another important contribution by Dr. White was the description he gave of keratosis follicularis in two original articles which appeared in the *Journal of Cutaneous and Genito-Urinary Diseases* in 1889 and 1890. They were the first descriptions of the disease ever prepared by an American physician.

Dr. White enrolled at Harvard University at the age of 16 in 1849 and was graduated in 1853. He then entered Tremont Medical School in Boston, was selected as a "house pupil" at Massachusetts General Hospital in 1855, and received his M.D. in 1856. Upon receiving his medical degree, Dr. White journeyed to Vienna for a year's study, where he was exposed to many brilliant medical minds. They included such famous doctors as Josef Hyrtl, Ernest Von Brucke, Karl Rokitansky, Joseph Skoda and Karl Sigmund. He was influenced most by Dr. Ferdinand Hebra, whom Dr. White called "the founder of the modern school of dermatology."

He returned to the United States in 1857, and maintained a general practice in Boston. From 1860 to 1863, he devoted most of his time to a dispensary for skin diseases he had co-founded in Boston. In 1863 Dr. White was named one of Harvard's first University Lecturers to improve the education of future physicians. A colleague in this project was Oliver Wendell Holmes. Dr. White gave six lectures on common skin complaints, the first such instruction ever given at Harvard Medical School.

It was an address that Dr. White delivered in 1870 at the opening of the University's winter lecture courses which led, in 1871, to many reforms in medical education. These included a compulsory nine months' course, a graded curriculum extending over three years, and the requirement that each candidate pass a thorough examination in every department of medicine. In 1871, Dr. White was named the first full professor of dermatology at Harvard Medical School.

Previous volumes in the "Leaders of Dermatology" series honored Noah Worcester, Louis Adolphus Duhring and George Henry Fox.

UMC Team Does Heart Transplant

A surgical team at the University Medical Center has performed the first human-to-human heart transplant in the southeastern states. The team was headed by Dr. James D. Hardy, professor and chairman of the department of surgery.

Recipient of the heart was Malcolm R. Whitten, a 48 year old Marks farmer who had suffered a series of cardiac episodes. The donor was not identified under a UMC policy of respecting the privacy of the family from whom the donor comes.

Dr. Hardy and his associates at UMC pioneered transplantation procedures by transplanting a primate heart into a patient in 1964. He also performed the first lung transplant, the first kidney autotransplant for ureteral injury, and the first adrenal gland autotransplant. Dr. Hardy has been a winner of the First Federal-University of Mississippi "Missy" award for distinguished contributions to surgery.

The UMC surgical team has been prepared for the heart transplantation procedure for some time, awaiting the circumstance of the patient in need and the availability of a donor.

Biopharmaceutics Is Subject of PMA List

The scope and importance of the science of "biopharmaceutics" are detailed in an extensive bibliography just published by the Pharmaceutical Manufacturers Association.

"This unique publication refutes the astonishing myth that there are no significant differences among dosage forms of the same drug," C. Joseph Stetler, president of the association, said.

The bibliography contains abstracts and journal references on the influence of pharmaceutical formulation on the therapeutic activity of drugs. Listed are 501 citations. They establish a literature base in a field where, in a broad sense, some ten thousand articles are published annually.

The compilation is an outgrowth of testimony presented before the Monopoly Subcommittee of the Senate Small Business Committee. In these hearings some witnesses suggested that differences in formulation of drug products were negligible or of minor significance in their effect on patients.

"The bibliography lists well-designed clinical studies to show the opposite is true," Stetler said. "They describe clinically measurable differences among widely varying and widely used classes of drugs beyond those already documented in the hearings."

"Since different formulations of the same drug made by the same manufacturer may produce different results in patients, it is hardly surprising that the same drug made by more than one company may differ even more markedly," Stetler explained. "No two companies make a drug in exactly the same way. Thus the variations denoted in the articles of this bibliography, whether subtle or pronounced, can have significant effects in patients."

"It is interesting to note," the PMA executive added, "that the extensive research required for this study failed to turn up a single reference establishing that all formulations of the same drug from a variety of sources are equivalent—or even probably equivalent. Yet this invalid assumption has been made repeatedly in proposed legislation at both state and federal levels."

Studies in the compilation indicate that drug uniformity cannot be established simply by testing the end product.

"Thus compliance with such standards as the United States Pharmacopoeia and the National Formulary is no guarantee of product effectiveness in actual patients," Stetler asserted. "This is not to imply any criticism of the USP and the NF, both of which have done outstanding work in developing drug standards. But it is to say that therapeutic equivalence can only be shown in the clinic or by well-designed *in vivo* or *in vitro* presumptive testing, complex and exceedingly costly as this may be."

"In the final analysis, the excellence of a product must depend upon the excellence of the manufacturer. There are no substitutes for quality control of a high order and consistently good manufacturing practices," Stetler said.

The PMA president pointed out that because of budget and manpower the FDA concentrates its inspections in major company plants, being unable to give much attention to the smaller firms that have the greatest number of product recalls.

"Yet member firms of the PMA, producing 95 per cent of the nation's prescription drug supply, have only 20 per cent of the recalls. Companies making only five per cent of available drugs are identified with 80 per cent of the recalls despite little regulatory attention. Such a record should be a warning to those who blandly assume the equivalency of drugs produced under a variety of conditions," he stated.

"To deny that formulation is important is to deny the very basis of the profession of pharmacy," Stetler said.

Of the 501 citations in the bibliography, 221 cover *in vivo* human studies, with the remainder concerned with studies in animals as well as *in vitro*. About 20 per cent appeared originally in the *Journal of Pharmaceutical Sciences* of the American Pharmaceutical Association.

"It should be borne in mind," the preface to the bibliography states, "that there is a massive body of information concerned with such subjects as: the stability of an active ingredient in a pharmaceutical formulation and the stability of the formulation itself as well as with preservatives, sterility, flavors, and other significant pharmaceutical factors which ultimately affect the therapeutic activity of a drug. Articles on these topics, however, were generally excluded. . . ."

Natchez-based Society Changes Name

Physicians of Adams and Jefferson counties have acted to redesignate the component body in that area as the Adams County Medical Society. The designation of the predecessor component has, for many years, been the Homochitto Valley Medical Society.

The action has been approved by the Board of Trustees of the state medical association, subject to final action of the House of Delegates at the 101st Annual Session. Redesignation of component societies takes the form of an amendment to the charter which may be made, under the By-Laws, only by the House of Delegates.

The society, already employing the new designation during the approval interim, named Dr. Wendell H. Kisner president for 1969. Dr. Allen M. Read was named vice president and president-elect, and Dr. Walter T. Colbert was re-elected to succeed himself as secretary-treasurer.

Elected to a two-year term as delegate to the Mississippi State Medical Association was Dr. Sidney O. Graves, Jr., and Executive Committee members include Drs. Philip J. Bayon, Thomas H. Gandy, Charles Stern, Donald F. Barraza, Clifford Tillman, and John I. Davis. All officers are from Natchez.

ACS Slates Three Sectional Meetings

The American College of Surgeons has scheduled three sectional meetings in 1969: Feb. 3-5, Omaha, Neb.; Feb. 24-26, Louisville, Ky., and March 10-12, Boston, Mass., the annual combined meeting for doctors and nurses.

Sectional meetings are short, concentrated scientific sessions held in strategically located cities throughout the United States, Canada, and some foreign countries. These meetings, like the annual five-day Clinical Congress, are designed to inform the medical profession at large about developments in surgery. What the doctors want and whom they want to hear determines the programs, which are planned by local committees with some suggestions from College officials.

Surgeons of outstanding ability will act as teachers, focusing attention on newest ways of handling everyday problems through panels, symposia, "How-I-Do-It" clinics, scientific papers, selected films. Each meeting features sessions in general surgery plus two or more surgical specialties.

Omaha, Neb., Feb. 3-5

Dr. John D. Coe, Omaha, Assistant Professor of Surgery, University of Nebraska College of Medicine, is chairman of the local advisory program committee for the meeting in Omaha, to be held at the Sheraton-Fontanelle Hotel, Feb. 3-5. In addition to general surgery, specialty sessions in Urology and in Orthopedics including trauma will be featured.

General surgery sessions will include discussions of emergency department problems, infections, cancer of the colon, malignant melanoma, intestinal obstruction in children, organ transplantation and 14 "How-I-Do-It" reports.

Orthopedic sessions will include panels and reports on athletic injuries and a "How-I-Do-It" clinic discussing "throwing" injuries of the elbow, walking cast for tibial fractures, synovectomy of interphalangeal joints and elbow fractures in children.

Urology sessions will feature panels on iatrogenic injuries to the ureter, urinary incontinence, ureteral reflux and undescended testis.

Assisting Dr. Coe on the local advisory program committee are the following Omaha Fellows of the College and their specialties: Leon S. McGoogan (gyn-ob); Louis J. Gogela (neurosurgery); Stanley M. Truhlsen (ophthalmology); Robert E. Hawkins (otolaryngology); L. Thomas Hood (orthopedics); John W. Gatewood (plastic); John H. Brush (proctology); Clif S. Hamilton, Jr. (thoracic); William J. McMartin (urology); and in general surgery Charles W. McLaughlin, Jr., Merle M. Musselman, Fletcher A. Miller, Robert J. Fitzgibbons, William Clayton Davis and Arnold W. Lempka.

Louisville, Ky., Feb. 24-26

Dr. James C. Drye, Professor of Surgery, University of Louisville School of Medicine, is chairman of the local advisory program committee for the American College of Surgeons Sectional Meeting in Louisville, Feb. 24-26, at the Brown Hotel. This meeting will feature the specialties of gynecology-obstetrics and neurosurgery in addition to daily sessions in general surgery.

A symposium on trauma will open the meeting, featuring developments in transportation and management of the injured, and various acute injuries. The "Louisville Plan"—a pioneer plan of

direct transport of the seriously injured and ailing from ambulance to operating room or intensive care unit will be reviewed. Three sessions will be devoted to scientific papers, with subject matter ranging from Use of Low Molecular Weight Dextran in Shock to Peripheral Artery Surgery and the General Surgeon. An innovation at this meeting will be "Fireside Chats"—informal, end-of-the-day discussions with program participants, open to all questions from all registrants.

Treatment of injuries will be prominent throughout the three-day meeting, with topics ranging from acute injuries of the head, skeletal, maxillofacial, pancreas and duodenum to treatment of massive liver injuries and emergency care of eye injuries.

The relationship between directors of hospitals, administrators and nursing organizations—harmonies and conflicts, will be another area discussed in general sessions.

The Gyn-Ob program will include reports on endometriosis, surgical problems in pediatric gynecology, surgical management of childbirth injuries and surgical problems in pelvic cancer.

Neurosurgery sessions will include discussions of preoperative management of patient with ruptured intracranial aneurysm, clip grafts, microsurgery, carotid ligation and its sequelae, "How-I-Do-It" reports on recent advances in percutaneous chordotomy, surgery transplant of carotid-cavernous fistulae and carotid artery surgery for cerebral vascular insufficiency. "What's New in My Department" will be discussed by four department heads of medical schools.

Assisting Dr. Drye on the program planning committee are the following Kentucky Fellows of the College:

Douglas M. Haynes (gyn-ob); Thomas M. Marshall (neurosurgery); Roderick MacDonald, Jr. (ophthalmology); George I. Uhde (otolaryngology); Owen B. Murphy (orthopedics); Harry D. Stambaugh (plastic); John S. Harter (thoracic); Robert Lich, Jr. (urology); and general surgeons Rudolf J. Noer, Allan M. Lansing, Loren J. Humphrey, Robert W. Robertson, Clyde C. Sparks, Richard F. Grise, William T. McElhinney, James E. Hix and David A. Hull.

Joint Meeting for Doctors and Nurses, Boston, March 10-12

Dr. Bentley P. Colcock, Assistant Clinical Professor of Surgery, Boston University School of Medicine, heads the committee planning the program for doctors, and Miss Kathryn L. O'Donnell, R.N., Chief Nurse, Overholt Thoracic Clinic, Boston, the program for nurses. The Sheraton-Boston will be headquarters for doctors and the Statler-Hilton for nurses. There is no registration fee for nurses.

In addition to general surgery, there will be programs in eight surgical specialties: proctology, orthopedics and trauma, thoracic and cardiovascular surgery, gynecology-obstetrics, otorhinolaryngology, ophthalmic surgery, urology, and plastic surgery.

General surgery sessions will range from day-to-day problems in pediatric surgery to present status of organ transplantation. A special feature will be a session on What's New in Surgery? This sectional meeting will also include an industrial exhibit showing new accessories and equipment useful to the surgeon.

Boston Fellows of the College assisting Dr. Colcock, and their specialty representation in the program, include:

Howard Ulfelder (gyn-ob); H. Thomas Ballantine, Jr. (neurosurgery); Joseph M. Clough (ophthalmology); M. Stuart Strong (otolaryngology); Thomas B. Quigley (orthopedics); Bradford Cannon (plastic); Neil W. Swinton (proctology); John W. Streider (thoracic); Hartwell J. Harrison (urology); and, for general surgery, Frederick P. Ross, Herbert D. Adams, John J. Byrne, Marshall K. Bartlett, Ralph A. Deterling, Jr., William Silen, and Samuel R. Schuster.

The nurses concurrent sessions will include discussions of future education for nurses, nursing law, bacteriological housekeeping in the operating room, current reports on burn care—including anesthesia, hypnosis and surgical management, materials, procurement and supply distribution, disposables versus reusables, advanced surgical procedures on the heart, liver, kidney, adrenals and pancreas, surgical technique of portacaval shunt and thoracic surgery in children. Important new nursing films will be shown. Mrs. Esther Katz, R.N., Operating Room Consultant, is co-chairman for the nurses program.

Some 25-30 industrial exhibits will be on display at this meeting. Dr. Woodrow L. Pickhardt, Chicago, assistant director, is in charge of the scientific program for these three sectional meetings.

Official housing forms for all meetings are available from: Mr. T. E. McGinnis, Manager of Exhibits and Meeting Arrangements, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

Prairie Medical Names 1969 Leaders

Dr. John R. Mullens, Jr., of West Point has been inaugurated president of the Prairie Medical Society. Named to the post of president-elect is Dr. Elton S. Thomas of Columbus.

Dr. L. H. Brandon of Starkville is serving as the society's secretary. The group conducted its fourth quarterly meeting of 1968 at the Mississippi State University Student Union where the members and their ladies were entertained by the MSU Madrigal Singers.

The society area consists of the counties of Clay, Lowndes, Noxubee, and Oktibbeha.

PMA Will Train Packaging Employees

Pharmaceutical industry employees responsible for the highly-demanding task of packaging prescription drugs can soon improve their skills and their career opportunities via a self-training program announced today by the Pharmaceutical Manufacturers Association.

PMA President C. Joseph Stetler termed the self-instructional learning system "a totally new type of service" provided by the association for its 130 member firms. He pointed out that the self-training program will actually serve a dual purpose by improving employees' career opportunities and, at the same time, assuring the general public of an even higher degree of precision in the vitally important area of packaging prescription drug products.

Designated as a modular packaging mechanics training course, the program is being developed for PMA by the Westinghouse Learning Corporation. More than 50 PMA member firms have already indicated intentions to take advantage of the 60-module course, the first modules of which will become available in the latter part of 1968.

A total of 205 course hours are involved, covering seven major packaging topics under the titles of basics, power sources, power transmission, controls, packaging materials, packaging equipment, and preventative maintenance.

Modules in the curriculum range from basic mathematics and safety to such specific packaging topics as cottoning, capping, labeling, and cartoning.

Dr. John C. Adams, vice president of scientific and professional relations at PMA, will serve as the association's coordinator and provide liaison between PMA and Westinghouse. He explained that the format and styling of the program is designed to aid the trainee in performing such functions as troubleshooting and trouble correction.

A minimum of tenth-grade reading ability and general background knowledge of academic subjects, specifically mathematics and science, are required of all enrollees, as is some familiarity with basic shop practices, the use of tools, and general safety. Also, a general orientation to the equipment of a specific or typical pharmaceutical packing operation is required.

A subcommittee of PMA's Production and Engineering Section worked with Westinghouse in developing the self-training program as a "multilevel presentation." This enables better qualified trainees to pass instructional units at less detailed levels, while providing more involved levels of presentation for slow learners. Such compensation for individual differences means that only units required for each individual trainee need be studied.

The Westinghouse Learning Corporation is engaged in developing improved learning systems, services, instructional materials and equipment for industry, government and educational institutions.

MHA Announces Grant, Fellowship Programs

The Mississippi Heart Association has announced its 1969-70 research grant and fellowship program. Applications must be received on or before March 1, and awardees will be announced on July 1.

Spokesmen for the association said that a total of $61,500 was awarded in 1968. Seven departments of the University of Mississippi received a total of $45,500 in fellowships, each at a level of $6,000 base plus $500 maximum dependency fund.

Eight individual investigators were awarded a total $16,000 by the association in equal grants of $2,000 each.

The heart association said that grants are made to nonprofit institutions in direct support of an investigator who has received his doctorate within the past year. The duration of the grant awards, made in the cardiovascular field or basic sciences

MPAC

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give you IMPACT, doctor!

But make it a mutual impact, doctor, because your PAC needs you and you need your PAC. Both AMPAC and each of the 50 state PAC's are voluntary, nonprofit, unincorporated, autonomous groups whose members are physicians, their wives, and others in allied professions. Every group is bipartisan, bound by no party label. The voting record, platform, and program of a candidate—not his party—is what the PAC considers.

The basic purpose is twofold: To educate in political affairs and to provide a means through which the physician-citizen can effectively make his voice heard in the political arena. MPAC is medically oriented and medically directed by a 10 member board consisting of nine physicians and a Woman's Auxiliary representative.

With the elections behind, MPAC is looking ahead to 1970 when there will be a job to do. Make your voice count by sending your dues today, $10 for MPAC and $10 for AMPAC. Better send dues for your wife, too.

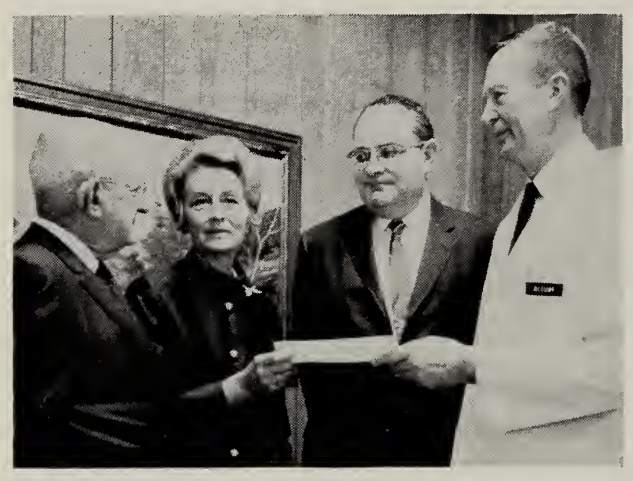


MISSISSIPPI MEDICAL
POLITICAL ACTION
COMMITTEE

related to it, is one year. Except under unusual circumstances, the grants do not exceed $2,000 each.

In addition to the grant and fellowship programs, the heart association continues to contribute $20,000 annually in support of the Love Memorial Chair of Cardiovascular Research at UMC.

Kidney Foundation Supports Dialysis Project



The Hinds County Kidney Disease Foundation contributed $5,000 to the University Medical Center fund for establishing a home dialysis training program. Presenting the check to Dr. Robert E. Blount, right, assistant dean of the school of medicine, are, from left, Dr. H. C. Ricks, organization president, Mrs. Bernard M. Jones, co-founder of the county organization, and J. Edmund Johnston, foundation treasurer.

Insurance Industry Contributes $1.4 Million

Thirty-six grants and 18 Medical Scientist Fellowships totalling $1.4 million will be awarded by the Life Insurance Medical Research Fund in its 1969 program.

The awards, effective July 1, 1969, were announced by the Fund's Advisory Council—during the organization's recent annual meeting in New York.

The Medical Research Fund, supported by 125 life insurance companies in the United States and Canada, have presented annual awards since 1945 to aid medical research in the biological and life sciences.

Twenty-nine institutions and one hospital will share more than $1 million in grants for the upcoming academic year. Eighteen researchers at 14 universities, who are in study programs leading to the combined degrees of M.D. and Ph.D., will share another $345,000.

Two men—whose medical research has been supported by the Fund—were guest speakers at the meeting. One was Dr. Robert F. Forster II, chairman of the department of physiology of the University of Pennsylvania Graduate School of Medicine, who has received more than $182,000 from the Fund since 1956 for research on pulmonary blood flow at the University of Pennsylvania.

The second speaker was Dr. Peter A. Lee, a recipient of $16,500 from the Fund, has been a Medical Scientist Fellow since 1965. A Ph.D., he will receive his M.D. from the University of Michigan Medical School in June, 1969.

New NIH Branch Studies Cancer Therapy

Research designed to improve drug treatment of cancer by exploiting differences in the reproductive cycles of normal and malignant cells will be emphasized in the work of a newly established Human Tumor Cell Biology Branch of the National Cancer Institute, National Institutes of Health.

Creation of the branch was announced by the Institute director, Dr. Kenneth M. Endicott, who said the research will be supervised by Dr. Seymour Perry, Associate Scientific Director for Clinical Trials, as branch chief.

Dr. C. Gordon Zubrod, Scientific Director for Chemotherapy, explained that Dr. Perry and his colleagues will investigate physiologic, cytogenetic and biochemical control mechanisms at the molecular level of human cells. The dynamics of cell growth and characteristics of reproductive cycling, called cell kinetics, will be studied in such types of cancer as the leukemias and lymphomas, in solid tumors of the breast and lung, and in normal cells.

Lung cancer studies will be conducted with the cooperation of the National Cancer Institute-Veterans Administration Medical Oncology Service at the Washington, D. C., Veterans Administration Hospital.

Southwest Society Elects Officers

The Amite-Wilkinson County Medical Society will be led in 1969 by Dr. Sam P. McManus of Gloster who was recently inaugurated president concurrently with his election as chief of staff at the Field Memorial Hospital in Centreville. Dr. Jack Causey was named president-elect and Dr. James S. Poole, secretary. Both are from Centreville.

Dr. Keith Miller of Woodville, a practicing dentist, was named secretary of the hospital staff. The simultaneous elections also included the making of appointments to the staff for 1969.

M.D.'s Are Nominated Appalachia Advisers

Three members of the Northeast Mississippi Medical Society have been nominated to Governor John Bell Williams who will select one as the state medical association's representative on the Mississippi Appalachia Health Advisory Committee. The nominations were made by President Joseph B. Rogers of Oxford.

Named to the state's chief executive were Drs. J. T. Davis of Corinth, Bobby F. King of Iuka, and S. Jay McDuffie of Nettleton. The governor is expected to act on the nominations during February.

Heading the advisory committee is Dr. Rudyard B. Robinson of Saltillo who will preside over the multidiscipline group. He represents the state government, having been selected by Governor Williams.

The Appalachia program contains wide authorities for federal assistance to 13 states from West Virginia to Mississippi as a contiguous economically depressed area. There are 20 Mississippi counties, all in the northeastern portion of the state, in the federally-defined area.

Flea Collars May Cause Dermatitis

Skin irritations in four human subjects were traced to petting or handling dogs wearing antiflea collars, two Atlanta dermatologists report.

All the collars contained an insecticide which is capable of producing primary irritant dermatitis and even chemical burns, according to Dr. Paul C. Cronce and Dr. Herbert S. Alden, who have clinical appointments in the department of medicine, Emory University School of Medicine.

In a clinical report in the *Journal of the American Medical Association* Nov. 11, the physicians said they observed the four patients in a six-month period. The skin conditions resembled "mild poison ivy dermatitis," they explained, and "the occurrence of dermatitis followed close contact with dogs wearing flea collars."

The insecticide in the collars is composed of 93 per cent 2,2-dichlorovinyl dimethyl phosphate and 7.0 per cent related compounds; the antiflea substance is "a known poison which inhibits cholinesterase," the doctors said.

"It would appear that many cases of irritant dermatitis caused by this insecticide in antiflea collars have gone unrecognized, and when looked for, this dermatitis may well be found with some frequency," said the JAMA report.

EEG Course Is Scheduled at Houston

A course in current problems in electroencephalography and advances toward their solution will be jointly sponsored by the American EEG Society and the Baylor University College of Medicine. The course will be conducted at Houston, Texas, March 13-15, the announcement stated.

Physicians interested in attending the course may secure further information by communicating with Dr. Peter Kellaway, Baylor University College of Medicine, Texas Medical Center, Houston, Texas 77025.

Catholic Organization Sponsors Coast Meet

Physicians in the Gulf Coast area were recently invited guests to a seminar sponsored by the Pope John XXIII Forum on Post-Conciliar Theology. The subject was "The Moral Problem of Abortion."

Speaker before the seminar was the Rev. Richard A. McCormick, S.J., professor of moral theology at the Bellarmine School of Theology, North Aurora, Ill. The invitation to the seminar was extended by the Rt. Rev. Msgr. Edward F. Michelin, the representative for hospitals and health of the Bishop of the Diocese of Mississippi.

SBH Improves Garbage Disposal

Garbage cans have been banished in three Mississippi towns!

In their place sacks are used—specially treated disposal paper bags that hold the same amount of refuse as 20 gallon cans.

"For towns not able to buy packer-type trucks, we recommend sacks for storing refuse instead of garbage cans," said V. T. Hawkins.

And the State Board of Health's advisory sanitarian is talking about the majority of Mississippi towns. For just the body of a packer-type truck costs from $18,000 to $30,000, depending upon the size. On the other hand, a dump-truck costing $1,200 to $1,500 is suitable for collection of refuse sacks.

Refuse sack service was initiated in Picayune three years ago on a trial basis. Residents and city officials liked it so well, it has become a permanent public service. One resident, a very vocal lady, who vociferously opposed the initiation, today says she's "strictly sold on the idea now!"

Raleigh and Belzoni began refuse sack service the latter part of 1968. A number of other towns are using a combination of garbage cans and sacks while giving the latter a try-out.

To inaugurate the service, householders purchase the prescribed refuse sack lid and rim set. Made of metal, it costs around $3.00 and "lasts almost forever," says Mr. Hawkins. The only wearing part is a rubber seal that is replaceable. Some families need two sets, depending upon the amount of refuse stored between pick-ups.

One sack comes with each lid and rim set. Each time the garbage is collected a new sack is left to replace the one taken away. These sacks are furnished by the city, with the householder paying a nominal yearly service charge.

Since sacks cost only 9¢ a piece, sack service is cheaper for the householder than maintaining garbage cans—not to mention frustrations from bashed-in cans and ill-fitting lids.

The sack fits onto the lid and rim set very much like a vacuum cleaner bag: a metal hoop operated by a small level holds the bag securely. When the sack has been filled with refuse, it is easily removed by releasing the lever. Then the sack is closed by rolling over the top a couple of times to secure the contents until pick-up.

City officials in Picayune, Raleigh and Belzoni have high praise for their refuse sack service. They have found other advantages in addition to obviating the necessity of the expensive packer-type truck. Since there are no cans to empty and reset, garbage pick-up is now much less time-consuming for the town, thereby freeing personnel for other duties.

The only disadvantage to the use of sacks for garbage is that meat scraps must be wrapped. Even though the sacks are specially treated, they will absorb grease and become a lure to dogs unless precautions are taken.

At present the State Board of Health is studying the operation and utilization of sack service in Mississippi towns.

Medical Assistants Name 1969 Officers

Mrs. Mary Adeline Pace has received the president's gavel of the Central Mississippi Chapter of the Mississippi Association of Medical Assistants at the organization's first 1969 meeting.

Also beginning their terms of office were the president-elect, Mrs. Sally Sullivan; first vice-president, Mrs. Carolyn Harris; second vice-president, Mrs. Elizabeth Hampton; third vice-president, Mrs. Audrey Brady; secretary, Mrs. Winnie Sharpe; and treasurer, Miss Mary Brooks.

The Mississippi Association of Medical Assistants, an organization of the women assistants to the medical profession, is an affiliate of the American Association of Medical Assistants.

A graduate of Mississippi College, Mrs. Pace serves the medical profession as Administrative Assistant to Dr. Myra Tyler, Director of Pulmonary Research, Department of Medicine, University of Mississippi Medical Center.

American M.D.'s Aid Island Republic

Four volunteer medical doctors from the United States flew to the Dominican Republic to join local prysicians in combating an epidemic of common measles that has jammed hospitals and clinics on the island.

The American physicians conducted a week-long mass inoculation campaign to immunize 100,000 children throughout the island republic. The Dominican effort is patterned after successful mass-inoculation programs in the United States and Canada which have drastically reduced the incidence of measles.

"If all goes well, we can expect to reduce the incidence of measles in the island by 70 per cent," said Dr. James E. Bowes of the Pitman-Moore Division of The Dow Chemical Company. Dr.

Bowes is the organizer of the team of U.S. and Canadian physicians who will participate in the program.

Dr. Bowes arranged for the help from North America after a visit to the Dominican Republic just before Christmas. He observed the epidemic of measles on the island that has jammed local hospitals and clinics. "I felt a need to help out in a hurry, and the other doctors I talked to felt the same way. Pitman-Moore agreed to donate the vaccine," he said.

The doctors employed Hypospray Jet Injector guns without needles and 100,000 doses of Lirugen one-shot measles vaccine donated through the Pan American Development Foundation. They worked with professional representatives of the Dominican Health Ministry and Academy of Pediatrics from headquarters in Santo Domingo and under the direction of Dr. Mario Fernandez, minister of health.

The physicians expect to form four teams here with local physicians. Two of the teams will stay in Santo Domingo, capital city of the Republic, and two teams will travel by land to outlying communities. The clinics were opened January 9 with support from Dominican Republic radio stations.

Blue Shield Asks Medicare Improvement

Cooperation to improve the government's Medicare program for citizens over age 65 was pledged today by a top policy group of Blue Shield.

The Board of Directors of the National Association of Blue Shield Plans, following a weekend meeting, said that despite many difficult administrative requirements and unforeseen pitfalls, the 2½ year-old program has gone a long way toward meeting the needs of its aged beneficiaries.

In a statement issued at the conclusion of the NABSP Board meeting, Dr. Carl R. Ackerman of Glencove, New York, chairman of the Board, said:

"The major element of this success was due to the wisdom of Congress in allowing private insurance and prepayment organizations to handle the bulk of the programs administration."

Thirty-three Blue Shield Plans served as carriers for 60 percent of the more than 20 million Medicare beneficiaries and are currently processing about 430,000 Medicare claims a week. Blue Shield has 72 Plans in the United States, which are represented nationally by the National Association of Blue Shield Plans with headquarters in Chicago.

In recalling implementation of Medicare, Dr. Ackerman said:

"When you consider the sudden and massive impact of Medicare on the health care profession and on the private financing mechanism, it is remarkable that we were able to solve most of the problems.

"It was a back-breaking job, and I think every employee of Blue Shield should be enormously proud of what we accomplished."

The New York physician also said: "We are not going to rest on those accomplishments."

Dr. Ackerman, referring to the recent statement of the new nominee for Secretary of Health, Education, and Welfare, Robert Finch, that he is seeking a "rationalization" of these problems, commented:

"We are going to offer all of our resources to the incoming administration of President-elect Nixon as it wrestles with the difficult problem in the financing of health care services."

Thomas C. Paton, president of California Blue Shield and chairman of the Association's Government Programs Committee, pointed out that Blue Shield carriers, while facing a severely restricted labor market, were able to recruit, train, and supervise thousands of new employees.

"The private sector has made a tremendous investment in time, talent, manpower, and data processing equipment in Medicare," Paton said, "and without the dedication and expertise of private carriers the program could not have been launched successfully. There is no doubt that the government could not have implemented the program effectively itself."

Paton emphasized that Blue Shield Plans are using the same controls in Medicare as those established in their private business. He said:

"Even before Medicare was enacted, utilization review was an integral part of Blue Shield operations. Today, all Blue Shield Plans maintain a utilization review program as part of the membership requirements to operate as a Blue Shield Plan.

"We use computerized methods to determine reasonable charges and to weed out claims that appear to be cases of overutilization or abuse. Whenever we find possible abuse, we go to physician committees for review and adjudication."

He praised the medical profession for playing a key role in these review activities.

Both Dr. Ackerman and Paton said they were in complete agreement with the incoming administration's stated position that it will primarily seek to improve existing programs rather than passing new legislation.

"With a cooperative effort between government and the private sector," they said, "we believe that improvement can be made in Medicare. We pledge our cooperation in this effort."

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, July 13-17, 1969, New York, N.Y.; Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo. E. B. Howard, Acting Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.

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CONTENTS

ORIGINAL PAPERS

Permanent Cardiac Pacing for Heart Block — **83** HILARY H. TIMMIS, M.D.; JAMES D. HARDY, M.D.; and THOMAS M. BLAKE, M.D.

Complete Right Bundle Branch Block in Right Ventricular Overload — **88** RICHARD G. HUTCHINSON, M.D.

Subcapsular Rupture of the Spleen — **92** RICHARD J. FIELD, JR., M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXIII — **95** T. S. MCCAY, M.D.

Challenge of Disaster — **96** RAYMOND S. MARTIN, JR., M.D.

EDITORIALS

ASH: Mild Label for a Singeing Movement — **99** Cigarettes in Court

Well Done, SK&F! — **100** Medical TV Discontinued

The Tax Challenge for Medicaid — **101** Funding the Program

Moving Mountains: The Paperwork of Medical Care — **102** New Processing Coming

The Growing Issue of Abortion Reform — **103** Action in Legislatures

Medicine of the 1970's — **103** New Horizons

THIS MONTH

The President Speaking — **98** The Voice of Medicine

Medical Organization — **113** 1-B Is Tightened

Meetings — **121** Society Circuit

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Fitness Is Stressed in State Schools

Twelve schools in Mississippi are currently demonstrating what can be done to carry out the goals of the President's Council on Physical Fitness in cooperation with State Education Departments.

Each school schedules regular "visitation" hours in the hope that educators, local government officials, community leaders and others will visit the school to see the program in action.

Kermit R. Davis, assistant supervisor of physical education for the State Department of Education, who serves as state coordinator for demonstration center schools, frankly admits, however, that he is disappointed at the lack of response to this open invitation.

"These schools," says Davis, "have gone to a lot of trouble to meet the standards required of a demonstration-center school. Their programs should be thoroughly studied by educators."

Davis points out that all elementary schools in the state must have organized programs of physical education in order to be fully accredited for the school year starting in Sept. 1969.

"Many schools have no such program," says Davis. "They would do well to visit these demonstration schools in preparation for instituting programs of their own just a few months from now."

Davis is sending letters to every school in the state urging them to take a look at the demonstration schools before the current school year comes to a close.

The basic program for a demonstration school calls for five things, and the school can add others as it sees fit. Davis lists the five basic ingredients as follows:

1. Periodic health appraisals for all pupils.
2. Identification of the physically under-developed and measures to eliminate or alleviate their problems.
3. Periodic physical achievement tests to evaluate and motivate pupil progress.
4. A daily period of physical education emphasizing fitness for all pupils.
5. Five to fifteen minutes of developmental exercise at the beginning of each class period.

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"No school is too small to institute such a program if they meet these five basic requirements," says Davis.

He lists Mississippi's (12) participating schools as follows:

Hancock North Central Elementary in Pass Christian (433 pupils)

Prentiss Elementary in Laurel (315 pupils)

Crestwood Elementary School in Meridian (321 pupils)

Sandy Gavin Elementary School in Laurel (551 pupils)

Velma Jackson Elementary School in Camden (513 pupils)

West End Elementary at Meridian (688 pupils)

Northwest Junior High School in Meridian (958 pupils)

Idella Washington Junior High School in Laurel (246 pupils)

Carver Junior High School in Meridian (725 pupils)

Velma Jackson Junior High in Camden (157 pupils)

Meridian High School (900 in girls' program)

Velma Jackson High School in Camden (473 pupils)

UA Sets Pediatric Surgery Seminar

The division of pediatric surgery of the department of surgery, Medical College of Alabama, will present a two-day pediatric surgery seminar on April 11-12, in Birmingham.

The internationally-renowned physician, Dr. Robert E. Gross will serve as guest lecturer during the seminar. Dr. Gross is William E. Ladd professor of child surgery at the Harvard School of Medicine, Boston, and chief of cardiovascular surgery at Children's Hospital Medical Center, Boston. Dr. Gross and Dr. Ladd were co-authors of the first textbook written on pediatric surgery.

Physicians are cordially invited to attend this seminar. There is no registration fee.

If additional information is needed, contact Dr. Luther A. Longino, professor and director, Division of Pediatric Surgery, Department of Surgery, Medical College of Alabama, 1919 7th Avenue South, Birmingham, Alabama 35233.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

March 1969

Dear Doctor:

The nation's newest Blue Shield plan has been organized by the Nevada State Medical Association. Start-up funds were solicited from state's physicians, and National Association of Blue Shield Plans gave $12,500 for "free surplus." Plan will pay usual and customary fees for both in- and outpatient care.

> Nelson B. Neff, executive secretary of state medical association, will also be Blue Shield executive chief. New plan will administer Title XIX and CHAMPUS, taking over from association. Plan's directors are eight physicians and four laymen.

Key figure in chartering the new American Board of Family Practice was Dr. William E. Lotterhos of Jackson. Serving as chairman of the Board of Directors of AAGP, Dr. Lotterhos conducted liaison with AMA Council on Medical Education and Advisory Board to the Medical Specialties. New specialty has no grandfather clause and will even require diplomates to come up periodically for recertification.

"Quiet, please!" Although not the theme, it's the idea for AMA's First National Conference on Noise. The April 28-29 Chicago conclave will consider health hazards of environmental noise as it affects work, sleep loss, and hearing impairment. Essays will examine psychophysical and sociometric aspects of noise.

Three Alabama congressmen, Reps. Andrews, Bevill, and Nichols, are sponsoring bills to include chiropractic services in Medicare. Legislation appears especially inappropriate since U.S. Government denounced chiropractic as a cult in January. National Council of Senior Citizens also opposes inclusion of chiropractic under Part 1-B. Proposal has been rejected twice before by the Congress.

First federal funds in the controversial rat control program have been allocated to New York. The $3.6 million grant will assist a state program which has been in effect for years. New federal money will go to New York City, Buffalo, Rochester, and Poughkeepsie.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Masonite Gives Facility To County

Laurel - The 60-bed Masonite Medical Center was presented by its owner corporation to the people of Jones County in ceremonies on Feb. 28. Masonite President John M. Coates presided over transfer of the $1.5 million facility to the board of supervisors. The corporation built and has operated the facility in relation to its industrial installation at Laurel.

Antibiotic Makers Seek Damage Settlements

New York - American Cyanamid, Pfizer, Bristol-Myers, Upjohn and Squibb are seeking settlement of treble damage suits filed after 1967 verdict of antitrust violation in marketing and pricing of broad spectrum antibiotics. Upjohn and Squibb were not defendants in antitrust litigation. The companies say that they did not violate antitrust laws, and Cyanamid, Pfizer, and Bristol-Myers are pressing appeals in the case. Indications are that settlements offered in damage suits will be accepted.

FCC Fag Ban Puts Issue In Congress' Lap

Washington - The Federal Communications Commission's ban of cigarette advertising on radio and television puts the issue squarely in the lap of Congress. Present "labeling law" expires June 3, and same law prohibits federal control over cigarette advertising. Unless Congress extends measure, FCC edict will become effective and radio and TV will lose $250 million in cigarette commercials. Issue will be hot - not for advertising revenue loss - but over tax take of state and federal governments on cigarettes.

Governor Gives Kidney Unit Big Boost

Jackson - Governor John Bell Williams' administration is seeking new sources of funds to support the hemodialysis unit at the University Medical Center. Project was funded for three years, and grant is due to expire soon. Minimum cost of maintaining a patient is $10,000 per year. Additionally, appeal has been made for public support through Mississippi Kidney Foundation, Jackson.

ACS Will Study Hospital Infections

Chicago - The American College of Surgeons' Board of Regents has given the green light to its Committee on Pre- and Postoperative Care to initiate a new study of hospital infections. Project will be headed by Dr. William A. Altemeier of Cincinnati, and it will begin with a series of three symposia bringing together nationally known authorities. College tentatively plans to publish results under title "Prevention and Control of Surgical Infections."

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Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.



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Shield Benefits Are Up in Some Contracts

Insurance department approval of four contracts with increases in surgical-medical benefits has been received by Mississippi Blue Cross-Blue Shield, according to Dr. J. C. Woosley, president.

Under the new contracts available to groups of 10 or more, Blue Cross benefits remain unchanged, but the Blue Shield benefits have been increased substantially. All contain the new $450 Surgical Schedule which is a 50 per cent increase over the F300 Schedule.

The new contracts also contain medical benefits of $15 first day; $10 second day; and $5 per day thereafter. Anesthesia benefits have also been increased to provide 20 per cent of the surgical allowance with a minimum payment of $15.

In revealing the provisions of the new contracts, Dr. Woosley expressed pleasure that clearance had been obtained for making available to the people of Mississippi these broader health care benefits. He noted that Blue Cross-Blue Shield representatives will have full details.

IRS Issues Caution on Medical Deductions

A common error made by Mississippi taxpayers last year involved medical expenses, especially the deduction for medical insurance premiums, according to J. G. Martin, Jr., district director of Internal Revenue for Mississippi.

Martin emphasized that on itemized returns, one-half the premium paid for medical insurance, up to a maximum of $150, may be deducted in full as a medical expense without regard to the 3 per cent limitation.

Many persons failed to take advantage of this provision last year and had to file claims for refunds.

The balance of the premium cost for medical insurance should be added to other medical costs and reduced by 3 per cent of income. Life insurance and accident and health insurance covering the loss of earnings are not medical expenses and the premiums paid are not deductible.

Martin pointed out that all taxpayers must reduce medical expenses by 3 per cent of their income. Such medical expenses also include the cost of drugs and medicine that exceeds 1 per cent of income. The excess over this amount is deductible.

NIMH Team Visits State Regions

Representatives of the National Institute for Mental Health visited Mississippi recently to study the state's regional mental health programs, Dr. Dorothy N. Moore, program director for the Mississippi Interagency Commission, said.

"We continue to look forward," said Dr. Moore, "to showing the progress our state has made in developing regional programs for the mentally ill and mentally retarded since the establishment of the statewide effort two years ago."

The M.I.C., composed of the executive officers of five state agencies (Health, Education, Welfare, College Board and Mental Institutions), is the state agency for coordination of program planning for the mentally ill and retarded. It has spearheaded the planning of multi-county regional mental health and mental retardation centers.

Dr. Moore said the N.I.M.H. representatives visited Tupelo, Oxford, and Greenville and met with members of planning commissions in Region 3, Region 2 and Region 5, respectively. A mental health and mental retardation center already serves the seven-county area surrounding Tupelo, while plans are nearing completion for similar programs in the other two regions.

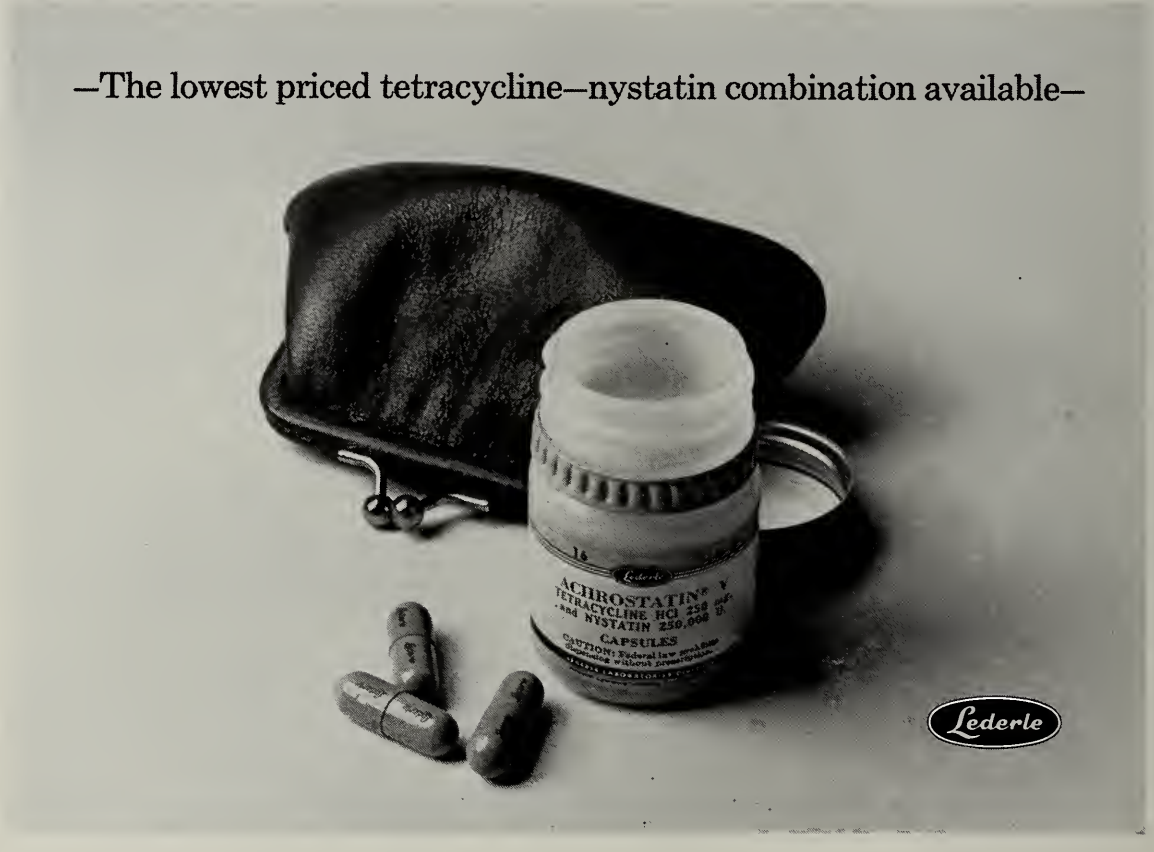
"The main purpose of these visits," said Dr. Moore, "was to observe methods which these regional programs are using to serve the rural areas of the participating counties. The three regions include a total of 18 counties."

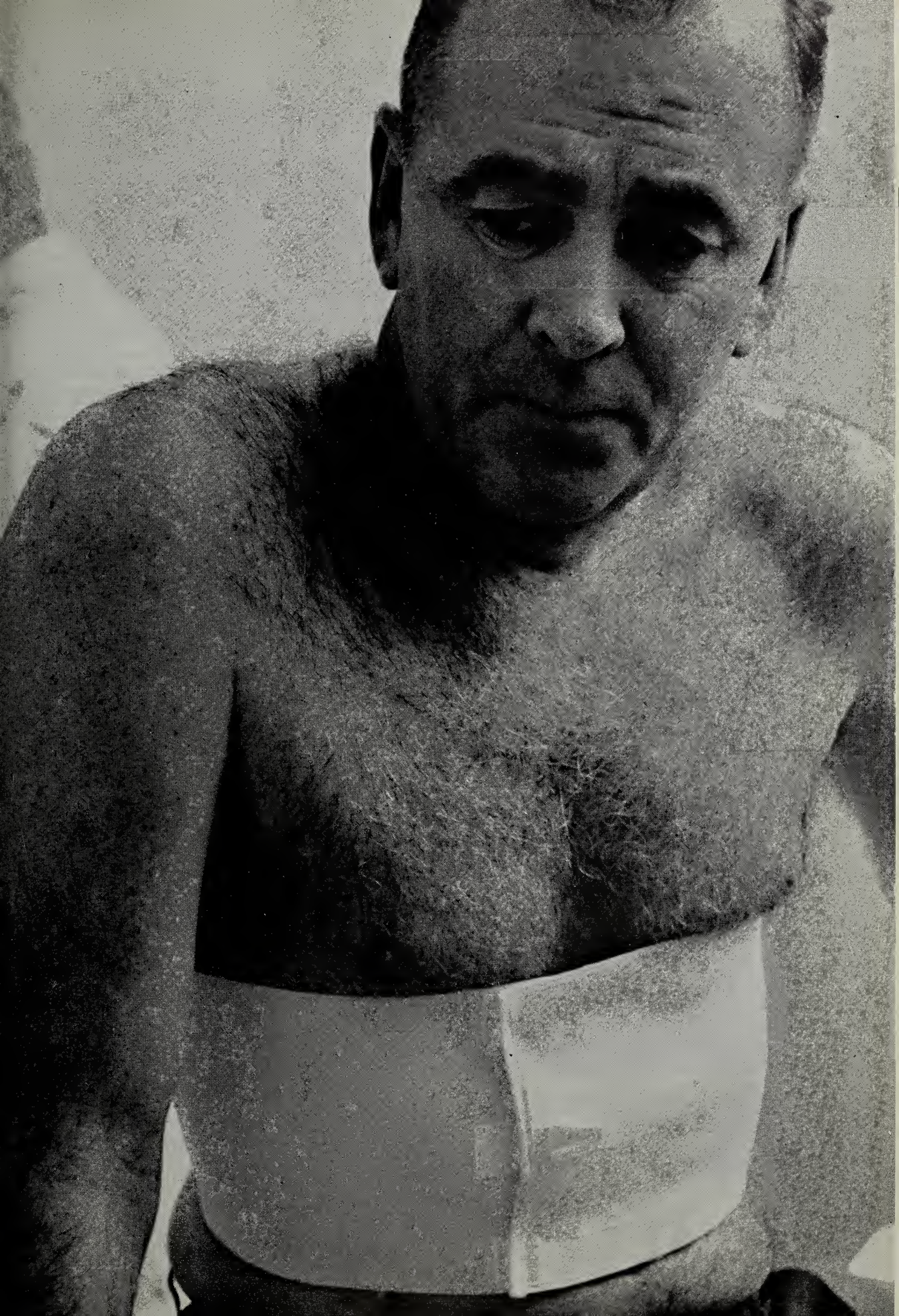
Visiting the state were Dorothea Dolan, special assistant for rural mental health, Technical Programs Assistance Branch; Dr. John R. Elpers, Continuing Development Section, Mental Health Facilities Branch; and Mrs. Lee Robinson, Mental Health Service Programs statistician, all from the N.I.M.H. in Chevy Chase, Maryland. They were accompanied by John R. Westmoreland and Clyde Dorsett, architectural consultants for the N.I.M.H.

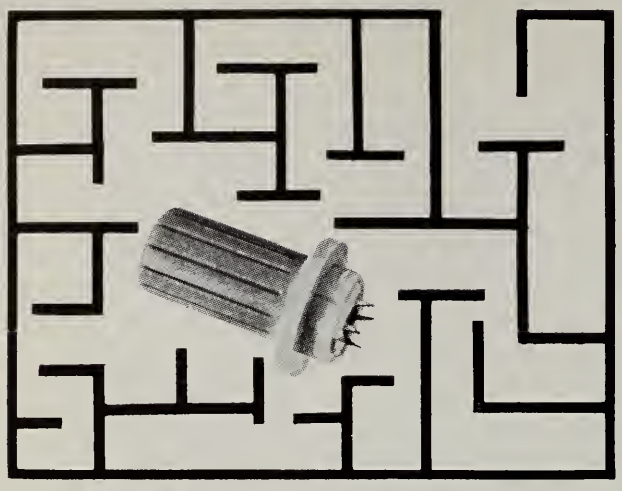
From the U. S. Public Health Region IV office in Atlanta were Dr. Nelms B. Boone and Miss Elyse McKeown, regional mental health consultants.

They were accompanied on their tour by Dr. Moore and by Jim Launch, M.I.C. program consultant.

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Self-service Sanitation Is Spotlighted by SBH

Trailer service—that's the name for a new type of garbage collection now operating in one of the state's rural communities that wanted to do something about an insanitary condition.

The place is the Bond community in Stone County, which up until last fall had no means of refuse collection or disposal.

A large trailer, 8 feet by 16 feet, is parked in an easily accessible area of the community. Here the residents bring their household refuse and deposit it in the trailer. When filled, the trailer is moved to the sanitary landfill where the refuse is disposed of in an acceptable manner.

The Board of Supervisors constructed the landfill and provide for its maintenance. They also handle the transporting and emptying of the trailer, which is specially constructed to afford proper drainage.

The origin of the trailer service goes back to a meeting of TAP—a technical action program for the Bond community. Charles Henderson, Stone County sanitarian, who is a member of TAP, invited V. T. Hawkins, Advisory Sanitarian for the State Board of Health, to confer with the group regarding various methods of refuse disposal applicable to the local situation.

Out of this conference the idea for trailer service was born. Immediately implemented by the Board of Supervisors, this innovation in collection methods has delighted the Bondites. It is being evaluated by the State Health Department as a possible answer to waste disposal in rural areas throughout the state.

The plan, according to Hawkins, is a modification of the trailer mobile service that is in operation outside the corporate limits of Huntsville, Alabama.

PMA Sponsors Drug Symposium

Six internationally-known research scientists will present papers at the first PMA drug research symposium, to be held at the Washington Hilton Hotel, March 6, it was announced by C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association.

Government, industry, and university scientists, science writers, selected congressional committee members and staff, representatives of international health agencies, and officials of pharmacy,

medical, and related scientific associations will be among those extended invitations to the one day meeting.

Following opening remarks by John J. Powers, Jr., vice chairman of the PMA Board of Directors, Dr. G. D. Laubach of Chas. Pfizer and Co., Inc. will moderate the morning session at which the following papers will be presented: *Antimetabolites—Comparative Biochemistry and Chemotherapy,* by Dr. George H. Hitchings, Burroughs Wellcome & Co. (U. S. A.) Inc.; *Calcitonin—A New Hormone Involved in Calcium Metabolism,* by Dr. Paul H. Bell, Lederle Laboratories; and *Clinical Pharmacology: Researching a New Drug in Man,* by Dr. Shelly G. Gilgore, Chas. Pfizer and Co. Inc.

Moderating the afternoon session will be Dr. Thomas P. Carney of G. D. Searle and Co. Papers which will then be presented are: *Recent Developments in the Chemotherapy of Schistosomiasis,* by Dr. Sydney Archer, Sterling-Winthrop Research Institute; *Contemporary Progress Toward Control of Viral Diseases of Man,* by Dr. Maurice R. Hilleman, Merck Institute for Therapeutic Research; and *Fertility Control—Contributions for the Future,* by Dr. Gordon W. Duncan, The Upjohn Company.

AHA Offers Heart Chamber Data

A summary of the proceedings of a 1967 Summer Workshop on the subject of "Measurement of Heart Chamber Volumes and Dimensions" has been published in booklet form by the American Heart Association.

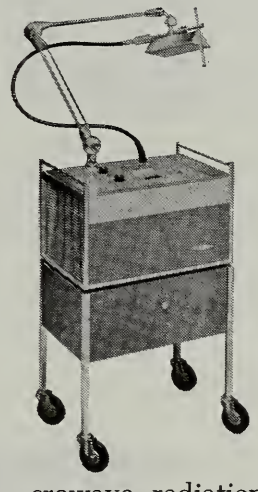
Sponsored by AHA's Council on Basic Science, the workshops are designed to provide an opportunity for discussion and evaluation of the current state of knowledge concerning some general area of basic cardiovascular research. At the 1967 sessions in Denver, "it was possible to concentrate in one place a significant representation of all the leading laboratories studying this problem in the United States," according to the 31-page booklet's foreword, written by Dr. Edward W. Hawthorne, Chairman of the Council on Basic Science.

Copies of the publication are available without cost in limited quantities from the AHA Distribution Department, 44 E. 23rd Street, New York, N. Y. 10010.

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Four new Blue Cross-Blue Shield contracts offer increase in surgical-medical benefits

New increased surgical-medical benefits are now available to groups of 10 or more through four new contracts offered by Blue Cross-Blue Shield. They contain a new $450 Surgical Schedule which is a 50% increase over the F300. Medical benefits include $15 first day, $10 second day, and $5 per day thereafter. Anesthesia benefits under the new contracts have been increased to provide 20% of the surgical allowance with a minimum payment of $15. Your Blue Shield representative has the full details.



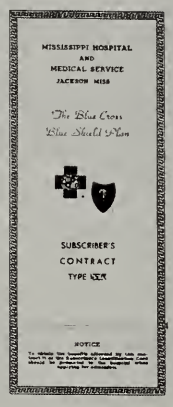
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$15 first day
$10 second day
$ 5 remaining days
$450 Surgical Schedule
20% Anesthesia Allowance
(minimum $15)



Type 138X

100 Days per confinement
$26 Room allowance
Comprehensive Ancillaries
In-Hospital Medical benefits
$15 first day
$10 second day
$ 5 remaining days
$450 Surgical Schedule
20% Anesthesia Allowance
(minimum $15)



Type 139X

100 Days per confinement
$30 Room allowance
Comprehensive Ancillaries
In-Hospital Medical benefits
$15 first day
$10 second day
$ 5 remaining days
$450 Surgical Schedule
20% Anesthesia Allowance
(minimum $15)



Type 140X

100 Days per confinement
Semi-private room in full;
Average cost of semi-private toward private accommodations
Comprehensive Ancillaries
In-Hospital Medical benefits
$15 first day
$10 second day
$ 5 remaining days
$450 Surgical Schedule
20% Anesthesia Allowance
(minimum $15)

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Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

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Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Div. Rexall Drug & Chemical Co., Northridge, Calif. 91324

MHA, MDA Urge Fat, Cholesterol Control

The Community Heart Program Committee of the Mississippi Heart Association and the Mississippi Dietetic Association jointly affirm earlier advice that people in Mississippi control the amounts of saturated fats and cholesterol in their diets if they hope to reduce the toll of cardiovascular diseases which now claim 11,000 Mississippi lives each year or an average of 30 every 24 hours.

Taking into account supporting scientific data accumulated over the past three years, the American Heart Association issued a new statement on Diet and Heart Disease which states there "is evidence that the risk of developing premature coronary heart disease can be reduced if prolonged high levels of cholesterol in the blood are avoided."

Copies of the revised statement on Diet and Heart Disease are available to physicians, nutritionists and scientific groups from the Mississippi Heart Association, P. O. Box 5002, Jackson, Miss. 39216.

Transplants at UMC Repeat 'Firsts'

A University Medical Center transplant team headed by Dr. James D. Hardy recalled two historical medical center "firsts" in January, 1969.

On Jan. 6 the team transplanted the healthy heart of a stroke victim into 48-year-old Malcolm Whitten of Marks, who had suffered eight severe heart attacks.

The heart spontaneously began a forceful beat and continued to function until Whitten succumbed to pneumonia following a cerebrovascular accident on Jan. 13.

The team had reported the nation's first heart transplant in 1964 when they put a chimpanzee heart into a dying man. That heart beat 90 minutes but proved too small to carry an adult load.

A new left lung was given Frank McCurley Jan. 18. The 66-year-old Crosby man had been in grave condition from chronic, severe pulmonary insufficiency due to emphysema in both lungs.

The medical center team had performed the world's first reported lung transplant in 1963 on 58-year-old John Russell who had both cancer and emphysema. Eighteen days later he died of preexisting kidney disease.

Some 20 persons from the UMC departments of surgery, medicine, anesthesiology and clinical laboratory sciences headed by Dr. Hardy contributed to both procedures.

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ORIGINAL PAPERS

Permanent Cardiac Pacing For Heart Block

HILARY H. TIMMIS, M.D.; JAMES D. HARDY, M.D.,
and THOMAS M. BLAKE, M.D.
Jackson, Mississippi

Forty-seven patients with A-V block of diverse etiology were treated by pacemaker implantation at the University Hospital. The operative mortality was 2.1 per cent, and there was a late mortality of 8.7 per cent. The authors analyze the causes of pacemaker failure and review their management.

THREE YEARS AGO the results of pacemaker implantation in four patients with heart block were reported in JOURNAL MSMA. Since then, a total of 50 cardiac pacemakers have been implanted in 47 patients and the pulse generator replaced in 16. During this period, preference has shifted from the fixed rate pulse generator and epicardial electrodes to the use of endocardial electrodes inserted by a per venous technique and demand units which deliver stimuli only when the pulse rate drops below a critical level. The purpose of this report is threefold: (1) to review the indications for cardiac pacing, (2) to update information concerning the pacemaker assemblies and methods of establishing cardiac pacing, and (3) to report long-term results at the University Hospital.

Cardiac pacemakers were implanted in 28 males and 19 females with an age range of 28 to 86 years. The average age of the women was about equal that of the men regardless of the etiology of heart block. Syncope and dizziness associated with bradycardia were the usual indications for hospitalization. Twenty-four patients had characteristic Stokes-Adams attacks and nine were in congestive heart failure at the time of admission. Symptomatic bradycardia was usually dramatically relieved when temporary preoperative pacing was established. Many patients appeared chronically ill, particularly in the older age group, and exhibited varying degrees of dehydration, azotemia, anemia, and muscle wasting.

On the basis of advanced age, a history of angina, and changes in the electrocardiogram, heart block was attributed to atherosclerosis in 42 patients. In three of these, cardiac pacemakers were implanted when a sinus mechanism failed to return following acute myocardial infarction. Idiopathic myocarditis requiring cardiac pacing was complicated by recurrent heart block in two premenopausal women. Congenital heart block

From the Departments of Surgery and Medicine, University of Mississippi School of Medicine.

and complete A-V dissociation complicating intracardiac surgery and myotonic muscular dystrophy were each seen on one occasion.

A-V block was documented in all patients. Persistent atrial ventricular dissociation was seen in 27 patients with ventricular rates ranging from 10 to 55 per minute. Alternating second or third degree heart block or second degree heart block alone occurred in nine others with rates of 28 to 44 per minute. Sinus rhythm with intermittent block was present in the remainder.

Forty-nine per cent were treated medically for periods ranging from three days to five years with regimens consisting of isoproterenol alone or combinations of chronotropic drugs with cortisone. The unreliable effect of these agents is indicated by the ultimate necessity for electrical pacing. Intravenous isoproterenol was used in two instances without significant improvement, and one patient required norepinephrine for five days to maintain a satisfactory arterial blood pressure despite satisfactory temporary artificial pacing.

METHODS

Temporary preoperative cardiac pacing with a bipolar endocardial electrode was used in 35 patients and usually resulted in immediate symptomatic improvement. Permanent pacing was instituted initially by the transthoracic method in 29 patients and by the transvenous technique in 18. With the former method, the electrodes were attached to the anterior surface of the left ventricle and the pulse generator placed subcutaneously in the abdominal wall (Figure 1). Per venous pacing, in turn, was established by the passage of a bipolar electrode, under fluoroscopic guidance, through the external jugular vein to the endocardial surface of the right ventricular apex. The pulse generator was positioned deep to the right pectoralis major muscle to avoid downward migration of the unit with subsequent retraction of the endocardial electrode (Figure 2). The stimulation rate was set at 70 to 74 per minute.

The current amplitude in epicardial pacemakers was adjusted midway between the threshold of stimulation and the level of maximal output, whereas in transvenous units, a level was selected at or near the maximal current output because the pulse generator was less accessible in the subpectoral position. Demand units which were used in 10 patients were adjusted to deliver 60 to 70 stimuli per minute during carotid massage if heart block was absent at the time of implantation. The pouch containing the pulse

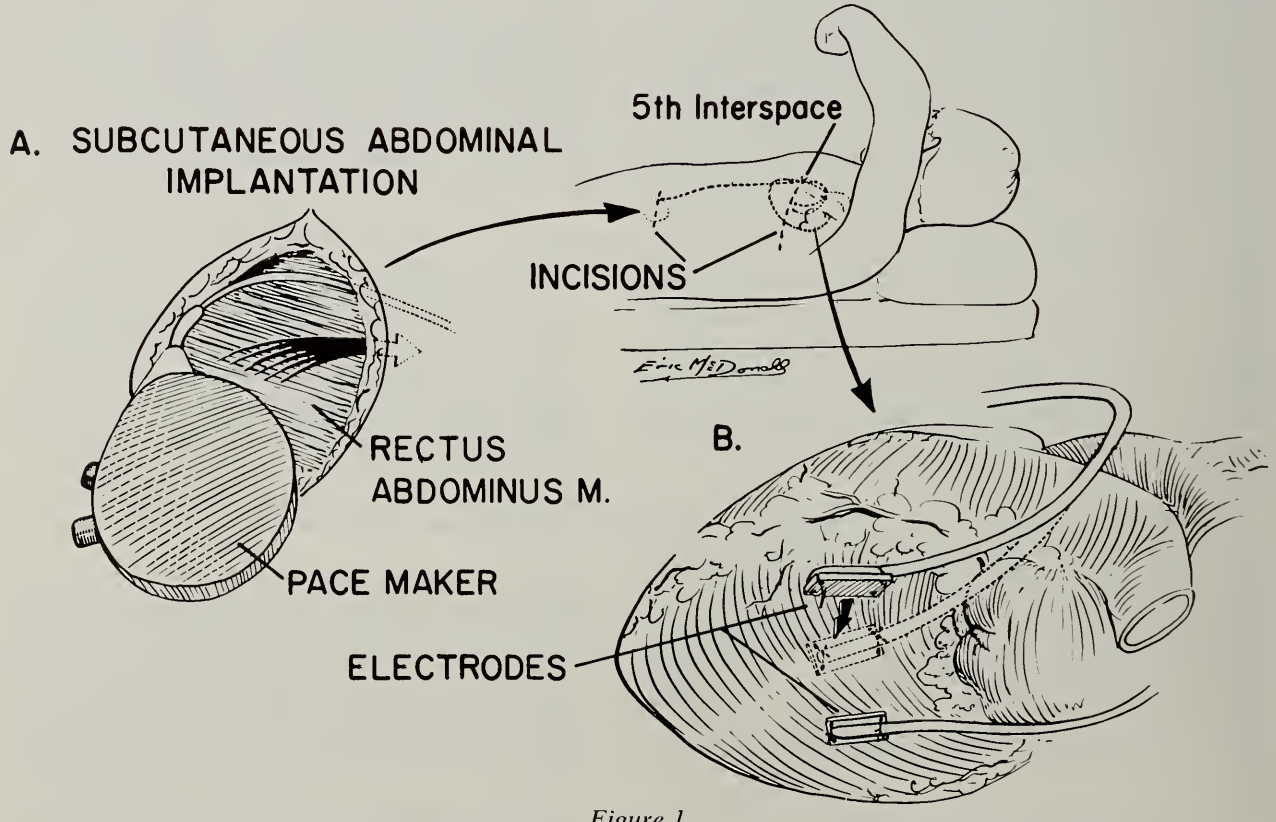


Figure 1

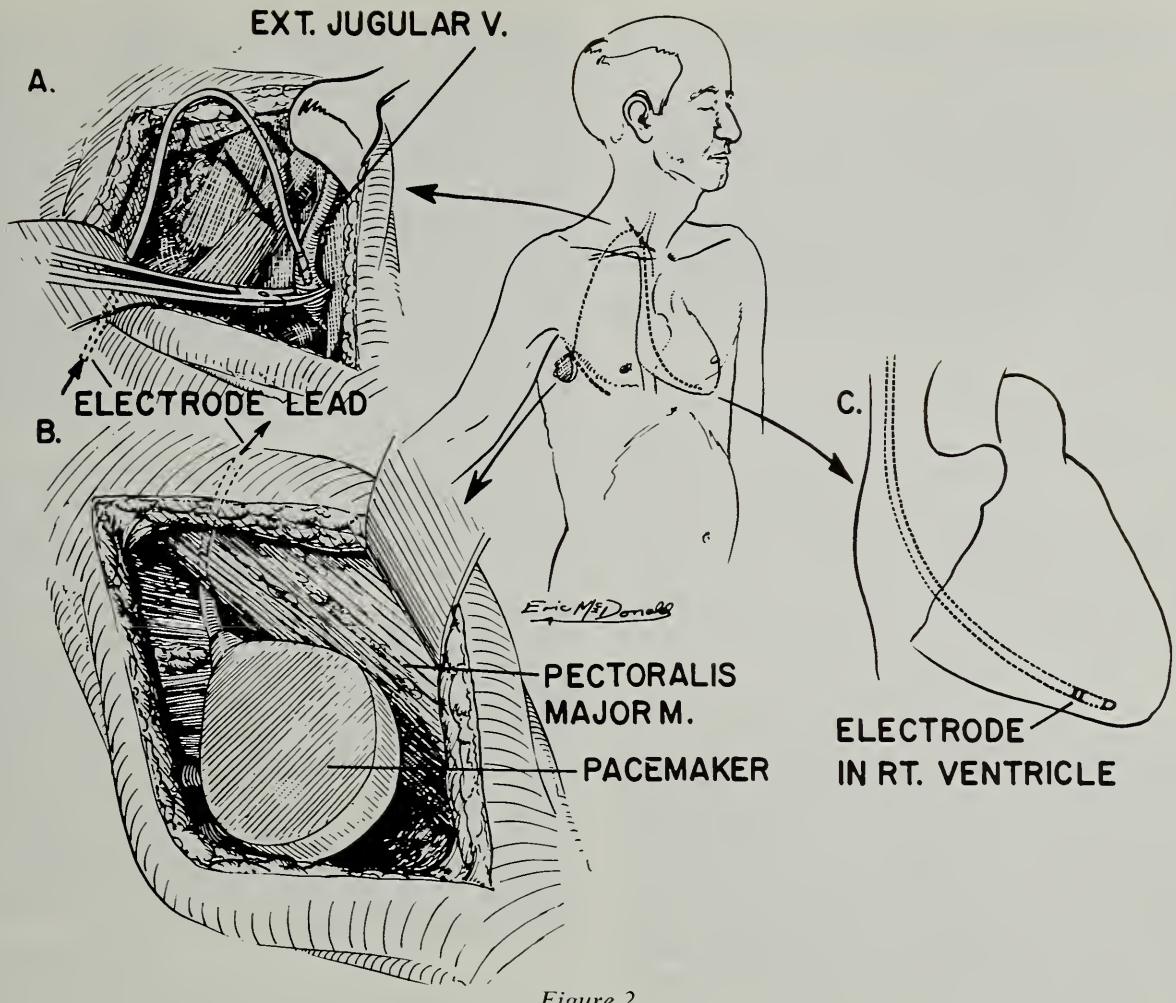


Figure 2

generator was drained for five days and broad spectrum antibiotics were administered for 10 days.

RESULTS

Immediate satisfactory cardiac pacing was achieved in all patients and the duration of hospitalization depended mainly upon the method of implantation and the nature of the underlying disease. Consequently, with one exception, those patients with acute myocardial infarction or idiopathic myocarditis had the longest hospital stays. The average postoperative hospitalization for all patients receiving epicardial units was 12 days, whereas, those receiving a transvenous unit usually were discharged within one week.

Three patients died of myocardial infarction 5 days to 15 months after implantation. Another expired after three laparotomies for recurrent upper GI bleeding during a prolonged hospitalization, and a fifth succumbed to the complications of strangulated intestinal obstruction three months after discharge. The 30-day mortality was, therefore, 2.9 per cent and the late mortality, 9 per cent (Figure 3). The remaining 42 patients have been followed from three weeks to four years and 10 months, and 39 have returned to a normal or near normal level of activity. The remainder have had one or more myocardial infarctions and their reduced level of activity is either self-imposed or involuntary.

Certain problems were met which were usually directly related to the methods of establishing cardiac pacing.

Prior to 1966, only epicardial pacemakers were implanted because of their established efficacy and reliability. However, in some instances the limited thoracotomy they entailed led to excessive immobilization, decreased pulmonary reserve and ileus. When the potential for this morbidity was present in more recent patients, a per venous method of pacing was used. Extrusion of the pulse generator occurred in three patients several months following implantation and was probably due to the proximity of the pulse generator to the abdominal flexion crease. In one pa-

tient, extrusion recurred four times despite reimplantation of the unit into progressively deeper planes of the abdominal wall and finally into the peritoneal cavity. An intolerance to the silastic coating on the pulse generator was suspected but not proved. Postoperative complications not directly related to the pacemaker per se are listed in Figure 4.

MORTALITY

Early (30 days)	
Myocardial Infarction	1
Per cent	2.1
Late	
Pulmonary Insufficiency and Upper GI Hemorrhage	1
Mesenteric Occlusion	1
Myocardial Infarction	2
Per cent	8.7

Figure 3

Unilateral, intermittent postoperative diaphragmatic stimulation was seen twice and was transient in character. Retraction of the endocardial electrode by movement of the shoulder or downward migration of the pulse generator was corrected in one patient by repositioning the electrode under fluoroscopic guidance. Diffuse edema and tenderness of the breast occurred in two females despite implantation of the pulse generator behind the pectoral muscle. The process resembled Mondor's syndrome and resolved spontaneously in one instance and in the other following reimplantation of the pulse generator into an abdominal pouch.

MORBIDITY (UNRELATED TO PACEMAKER)

Pulmonary Insufficiency	1
Post-Pericardiotomy Syndrome	2
Bronchopneumonia	1
Thrombophlebitis	1
Per cent	10.6

Figure 4

Early in our experience with both epicardial and per venous pacemakers, exit block due to a rise in the threshold of stimulation was commonly encountered. The relatively superficial position of the epicardial unit permitted percutaneous adjustment of the current amplitude with the restoration of pacing in all instances. Although the cessation of electrical pacing was commonly accompanied by the sudden onset of weakness and dyspnea, two patients sustained recurrent Stokes-Adams episodes. The incidence of exit block has been almost eliminated now by using a current amplitude midway between the threshold of stimulation and maximal output for epicardial and at the maximal level for per venous pacing. Component failure, which resulted in an intermittent rate increase and loss of rate control. was met twice and required replacement of the pulse generator. Pulse generator replacement has been carried out in 13 others for battery failure, which according to the specifications of the unit, was judged to be premature in three cases, i.e., less than 24 months.

Electrode failure was seen in two patients. In the first, intermittent pacing was due to fracture of one of the electrodes about five centimeters above the abdominal pulse generator. Continuous pacing was restored by converting the damaged electrode to an indifferent lead. Fracture of the remaining epicardial electrode at approximately the same level several months later necessitated implantation of a per venous unit. Severe bradycardia recurred in another patient three months after implantation of a per venous unit. Exploration revealed a markedly elevated resistance across one electrode. Cardiac pacing resumed after the side of abnormal resistance was converted to an indifferent electrode.

DISCUSSION

It is evident from this and other reviews that the surgical management of A-V block by pacemaker implantation is still less than ideal despite the low operative mortality met in treating patients with significant heart disease who are usually in the older age group. In our experience, the major inconvenience requisite to the delivery of this life-saving function is the necessity for pulse generator replacement due to battery failure. We have found that the average battery life of a functioning unit is 26 months with a range of 14 to 42 months when the current outputs recommended by the manufacturer for epicardial and per venous pacing are used. However, if one excludes battery failure as a complication of electrical pacing, the long-term morbidity following pacemaker implantation is low. Six patients required exploration of the pulse generator for a problem other than battery exhaustion. In three of these, it was eventually necessary to change from an epicardial to a per venous method of cardiac pacing for recurrent extrusion in one, recurrent electrode fracture in another, and a combination of extrusion and electrode failure in a third.

The low incidence of electrode fracture and failure of components other than the batteries attests the high state of reliability which these units have reached. Judicious positioning of the pulse generator to avoid major flexion creases in most cases will forestall fracture of today's electrodes. At the same time, meticulous implantation of the electrode tips into the myocardium proximal to the cardiac apex and the use of a generous loop of the insulated cables anterior to the pericardium will prevent fracture at this level.

Malfunction of components controlling rate of stimulation may, in turn, result in a "run-away" pacemaker syndrome and occasionally, in ventricular fibrillation. Emergency inactivation of the pulse generator which is usually indicated was not required by one of the patients in this series with documented paroxysms of tachycardia up to 150 per minute.

The usual gradual rise in cardiac rate heralding battery exhaustion is invariably noted if the pulse rate is determined periodically by the patient or a member of his family. Medical advice is invariably sought and leads to adjustment of the rate control or replacement of the pulse generator. However, the finger should not constantly be on the pulse of the asymptomatic patient and patients with pacemakers should be encouraged to resume their usual activities, including operation of an automobile, commensurate with their age and underlying disease.

Competitive pacing, which is present in 26 per cent of these patients, is characterized by a minor pulse irregularity resembling premature ventricular contractions. In the presence of a sinus mechanism, this arrhythmia is to be expected and the subsequent return to a regular pulse should be investigated with an electrocardiogram to document recurrent A-V block or pacemaker failure. Brief bursts of ventricular activity in those with per venous pacing will also produce an irregular pulse and in our experience is innocuous and limited to the early postoperative period. Thus far, we have met no complications attributed to competitive pacing. We are convinced, nevertheless, that the theoretical hazard of ventricular fibrillation due to the arrival of a stimulus during the vulnerable period of myocardial repolarization warrants replacement of exhausted power packs with demand units in those with parasystolic activity.

The demand unit is one of several exciting advances in the field of electrical cardiac pacing. The search for enduring power supply continues along many avenues including the development of better batteries,[4] the use of inductive coupling,[5] radio-frequency pulse transmission,[6] and more recently, the harnessing of energy released by motion[7] or oxidation within the body itself. New units incorporating the miniaturization of space age technology are just over the clinical horizon and are designed to provide more reliable cardiac pacing while further reducing the morbidity of this major therapeutic advance.

SUMMARY

Forty-seven patients, averaging 64 years of age, with A-V block of diverse etiology were treated by pacemaker implantation with an operative mortality of 2.1 per cent and a late mortality of 8.7 per cent. Permanent pacing was established by the transthoracic route in 29 patients with subsequent conversion to a per venous method in three. Eighteen others received subpectoral per venous implantation as the original procedure. Demand units were used in 10 patients. Subsequent exploration of the pulse generator was required in 18 patients, 72 per cent of whom had battery failure. Postoperative morbidity unrelated to the pacemaker was seen in 10.6 per cent and late pacemaker failure, excluding battery exhaustion in 10 per cent. The causes of pacemaker failure are analyzed and their management is reviewed. Our experience indicates that the fixed rate pacemaker has reached a high state of reliability and that battery failure remains the major unsolved problem. ★★★

2500 North State St. (39216)

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Complete Right Bundle Branch Block In Right Ventricular Overload

RICHARD G. HUTCHINSON, M.D.
Jackson, Mississippi

Charts of 59 patients were reviewed in a study of the incidence of complete right bundle branch block in a group of cardiac catherization patients with documented right ventricular overload. The patients were a heterogeneous group and included many different diagnostic categories. The author reviews the cases and discusses the results of the study.

IT HAS BEEN NOTED that in atrial septal defect, a condition which commonly overloads the right ventricle, the incidence of complete right bundle branch block is high.[1, 2, 3] In view of this, we felt that it would be interesting to review the incidence of complete right bundle branch block in a group of our cardiac catheterization patients with right ventricular overload. This was a heterogeneous group which included many different diagnostic categories.

Fifty-nine patients who had previously undergone cardiac catheterization were chosen and their charts were reviewed for evidence of complete right bundle branch block. The selection of these patients was based on the following points. First of all, a diagnosis capable of overloading the right ventricle (in either systole or diastole) was required. No patients were accepted for the series with right ventricular systolic pressure under 40 and in all but 15 it was 50 mm. Hg. or higher. Moreover, the 15 patients with right ventricular pressures below 50 had other evidence of right ventricular overload. Patients postoperative from cardiac surgery were not included because of the possibility of ventriculotomy induced right bundle branch block.

A table was made (Table 1) listing some of our patients along with the presence or absence of a left to right shunt, the right ventricular pressure, the presence or absence of complete right bundle branch block and the principal diagnoses. In our group of 59 catheterization patients, there were 6 with complete right bundle branch block for an overall incidence of 10.2 per cent. A breakdown of these 6 patients is given in Table 2. For comparison, the incidence of complete right bundle branch block in the population at large was sought from the literature and a study was made of 250 unselected, recent electrocardiograms pulled from our files. In the latter group we found five patients for an incidence of 2 per cent.

It is well at this point to define our criteria for the diagnosis of complete right bundle branch block. To make this diagnosis we required a QRS duration of 0.12 sec. or greater with anterior direction and slurring of the terminal forces. Some variety of the traditional RSR′ configuration in lead VI was seen in several patients but was not necessary for acceptance. An example is seen in Figure 1. In general our criteria for the diagnosis of complete right bundle branch block were in keeping with those enumerated by others. For example, Lipman and Massie[2] required a QRS duration of 0.12 sec. or more, increased intrinsicord deflection in right precordial leads, initial positivity in leads over the right ventricle, and a QR or rSR′ pattern in lead aVR. Lamb's[4] criteria included a QRS duration of 0.12 sec. or greater, rightward direction of the terminal vectors, and a broad terminal R′ wave in lead aVr and in V1. He noted that the QRS complex in lead V1 was either all positive or presented an rsR′ configuration. Similarly, Bauer's[5] require-

From the Department of Medicine, University of Mississippi School of Medicine.

TABLE 1

CARDIAC CATHETERIZATION CASES

Case No.	*Left to Right Shunt (L/min.)*	*Location of L to R Shunt*	*Right Ventricular Pressure*	*Complete Right Bundle Branch Block*	*Diagnosis*
1	—	—	75/4	No	Pulmonic Stenosis
2	4.9	Pulmonary Artery	90/0	No	Patent Ductus Arteriosus Mitral Stenosis Pulmonary Hypertension
5	14.1	Ventricular	RVI-136/0 RVO-100/0	No	Tetralogy* Pulmonary Hypertension
8	—	—	RVI-105/0 RVO-30/0	No	Tetralogy*
14	Questionable Left to Right (Right to Left Present Also)	Ventricular	120/0	No	Ventricular Septal Defect Persistent Left Superior Vena Cava Pulmonary Hypertension
16	14.5	Atrial	50/0	No	Atrial Septal Defect
17	7.0 (No Right to Left)	Atrial	100/4	Yes	Atrial Septal Defect Pulmonary Hypertension
28	Present. Vol. Not Available	Atrial Probably Ventricular Also	112/3	No	Tetralogy* Anomalous Pulmonary Vein
29	1.3 total 0.8 net	Atrial	90/12	No	Atrial Septal Defect Pulmonary Hypertension Partially Anomalous Pulmonary Venous Drainage Persistent Left Superior Vena Cava
36	10.0	Atrial	50/8	No	Atrial Septal Defect Anomalous Pulmonary Venous Drainage
40	3.5	Atrial	65/8	Yes	Atrial Septal Defect Pulmonary Hypertension
47	14.0	Atrial	45/5	No	Anomalous Pulmonary Venous Return
49	38.7	Atrial	40/4	Yes	Atrial Septal Defect
51	—	—	100/10 PC-35	No	Mitral Stenosis Aortic Stenosis Aortic Insufficiency
55	—	—	130/5 PC-20	No	Mitral Stenosis Pulmonary Hypertension

* Tetralogy here defined as all patients with Ventricular Septal Defects and Pulmonic Stenosis, with or without overriding of the aorta.

RVI means Right Ventricular Inflow Tract.
RVO means Right Ventricular Outflow Tract.
RV means Right Ventricular.
PC means Pulmonary Capillary Mean Pressure.
CRBBB means Complete Right Bundle Branch Block.

ments included a QRS duration of 0.12 sec. or greater, delayed right ventricular activation time, RSR complexes in right ventricular leads and a wide S wave in leads over the left ventricle.

We found that the incidence of right bundle branch block in the population at large was difficult to ascertain from the literature. According to Johnson[6] *et al.,* the average rate of complete right bundle branch block per 1,000 population between the ages of 20-40 was 1.5 (0.15 per cent). However, their figures were based on a number of routine electrocardiograms done to fulfill flying requirements in a group of healthy Air Force personnel and hence were not representative of the general population. A subsequent follow-up study[7] utilizing this same series and expanding the number of patients revealed 1.8 cases of complete right bundle branch block per 1,000 patients (all males).

In the 250 electrocardiograms taken from our

TABLE 2

ANALYSIS OF SIX PATIENTS WITH
COMPLETE RIGHT BUNDLE BRANCH BLOCK

Case No.	*Left to Right Shunt (L/min.)*	*Location of L to R Shunt*	*Right Ventricular Pressure*	*Diagnosis*
11	3.6 (Vol. Subject to Question)	Pulmonary Artery	55/4	Patent Ductus Arteriosus Pulmonary Hypertension Persistent Left Superior Vena Cava
17	7.0 (No Right to Left)	Atrial	100/4	Atrial Septal Defect Pulmonary Hypertension
21	—	—	150/0	Pulmonic Stenosis
40	3.5	Atrial	65/8	Atrial Septal Defect
49	38.7	Atrial	40/4	Pulmonary Hypertension Atrial Septal Defect
59	—	—	90/15	Primary Pulmonary Hypertension

files there were five cases of complete right bundle branch block by our previously defined criteria. Since most of these 250 electrocardiograms were taken on hospitalized patients, one would assume that the incidence of complete right bundle branch block would be somewhat higher than that found in the population at large. Hence, it appears that the incidence of complete right bundle branch block lies somewhere in between these two groups and in any case, it appears to be present in only a small percentage of the general population.

Taking our catheterization group at large, without regard to specific diagnostic categories,

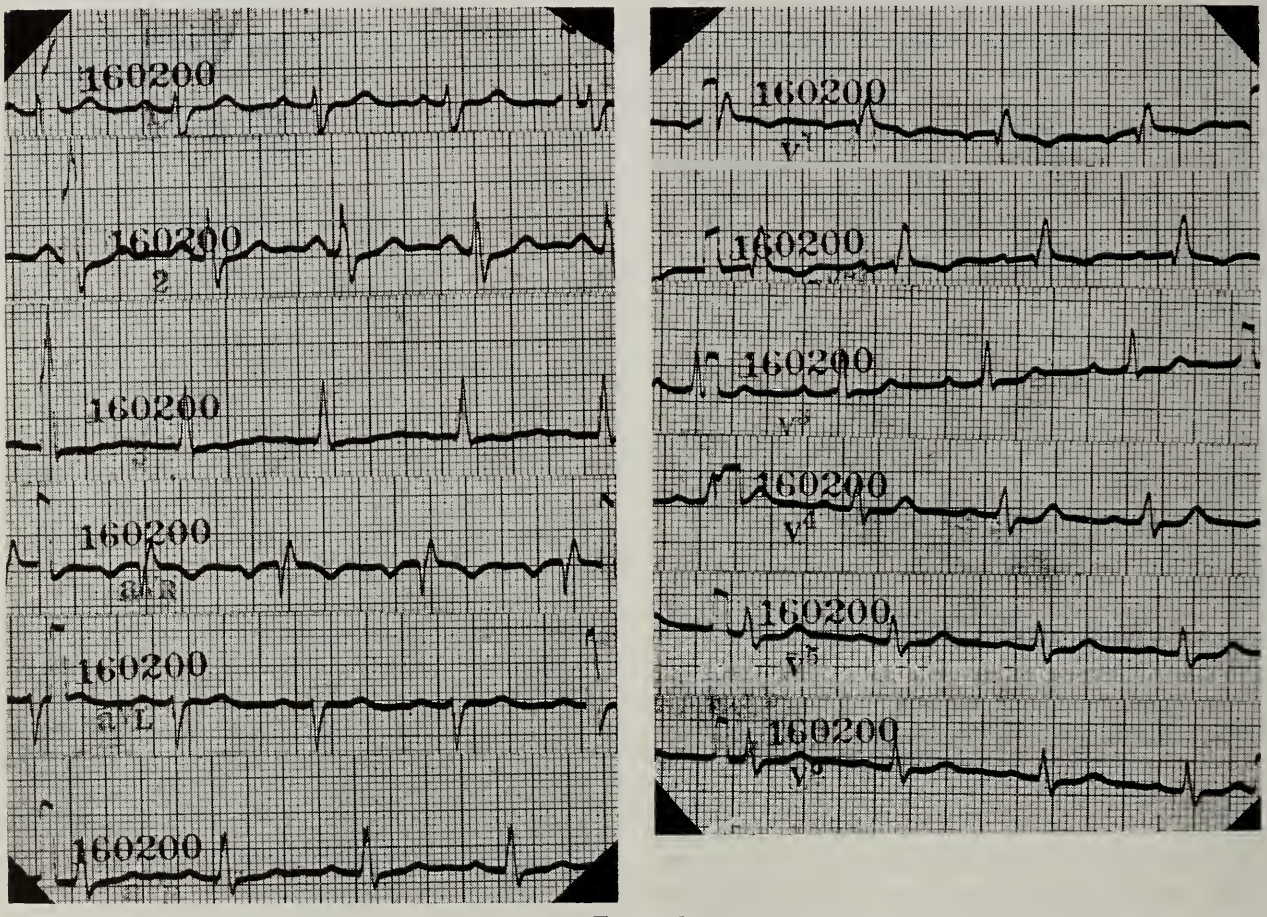


Figure 1

there were 6 cases of complete right bundle branch block in 59 patients for an incidence of 10.2 per cent. This is, of course, somewhat larger than the 2 per cent incidence found in the 250 electrocardiograms performed on hospitalized patients or the very low incidence reported in the two Air Force series. Unfortunately, the electrocardiograms in 2 of our 6 patients with complete right bundle branch block were not typical (cases 17 and 40) and in one of these (Case 40 —Figure 2) the right bundle branch block could

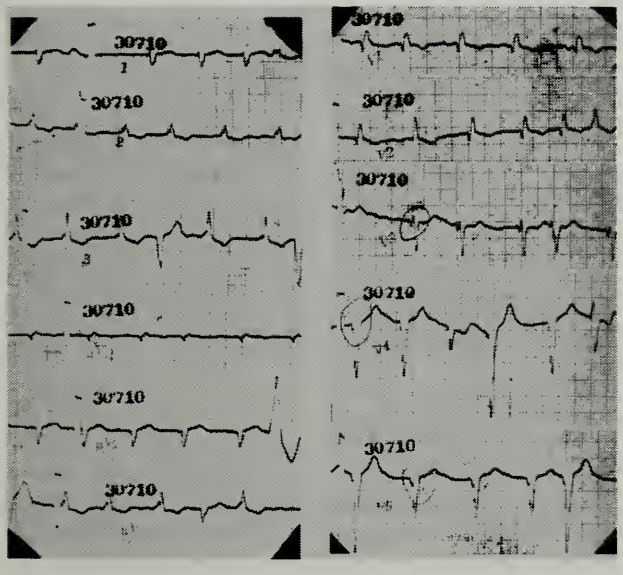


Figure 2

have been due to an old myocardial infarction. If these two electrocardiograms were excluded, the incidence of complete right bundle branch block in our group of patients with right ventricular overload would be 6.8 per cent.

Although our series of 59 patients represents a fairly large number of patients, we did not have sufficient numbers of patients to warrant commenting on the incidence of complete right bundle branch block in various diagnostic subgroups (for example, atrial septal defect, pulmonic stenosis, ventricular septal defect). However, it is generally accepted that the incidence of complete right bundle branch block is significantly increased in atrial septal defect and information gathered from the literature[1, 2, 3] supports this contention.

In a series of 59 patients with documented overloading of the right ventricle, the incidence of complete right bundle branch block appeared to be slightly higher than in the general population. However, the incidence in our group of patients was not high enough to draw diagnostically helpful conclusions. ★★★

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PULMONARY PREMIUM

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—Ed Hobgood, WJDX, Jackson

Subcapsular Rupture of the Spleen

RICHARD J. FIELD, JR., M.D.
Centreville, Mississippi

Subcapsular rupture of the spleen is a serious complication of abdominal trauma. A high index of suspicion with careful observation of physical, laboratory, and radiologic signs, prompt exploratory laparotomy and splenectomy should be done as soon as a tentative diagnosis is made.

RUPTURE OF THE SPLEEN is the most common and serious intra-abdominal complication of blunt trauma to the abdomen. This type injury is becoming a major problem in the present era of the automobile.

It has been stated by Woodward that one car in every 12 is involved in a serious crash during each 12-month period. This totals, according to Mehne,[1] a sum of almost two million injuries yearly. Thus it has been estimated that 35 per cent of all surgery performed in this country is related to some form of trauma.

Immediate or delayed rupture of the spleen is the most serious of the so-called "internal injuries" which occur with blunt trauma to the abdomen. Delayed rupture of the spleen is particularly lethal in that it occurs after the initial signs of injury have abated. The patient may even be at home following his hospitalization. Christopher[2] estimates that secondary delayed rupture of the spleen occurs in one out of every six cases. Thus the recognition of this injury is most important in the field of trauma.

The spleen is a soft spongy organ which is contained in a rather thick capsule. This thick capsule is the explanation for the delayed rupture of the spleen in that with blunt trauma there can be a tear within the spongy portion of the spleen which does not effect the outside capsule until the pressure within is great enough to produce a tear and then spillage of blood onto the abdominal cavity. The spleen lies against the ninth, tenth, and eleventh ribs on the left posterior side of the chest. Thus, it is fairly well protected in this area, but its friability makes it particularly vulnerable to blunt injuries. It is interesting to note that this organ though most vulnerable to non-penetrating injuries is least often affected by penetrating wounds of chest and abdomen as noted by Khanna.[3] The spleen is closely related to the left kidney and stomach thus any injury to these organs should suggest the possibility of splenic injury.

These patients initially may have very few signs of injury to this area but in general there has been some blunt trauma to the abdomen or chest with tenderness in the left upper abdominal quadrants and posterior left chest. There may be noted nausea or vomiting for a period of time after the injury and the patient may complain of left shoulder pain which is subsequent to diaphragmatic irritation. Contrawise a patient may immediately resume his work or his sports activity with minimal symptoms in this area. In cases of multiple injury these minimal symptoms may be completely overlooked while the other injuries are being treated and forgotten when the delayed rupture occurs. Frequently these cases are discharged to their homes following injury or they may never be admitted to the hospital at the time of their initial injury.

The latent period of rupture of the spleen as described by Baudet[4] (1902) generally does not extend over 14 days, but there have been cases reported in Mcindoe's[5] (1932) series as long as six months. But the delay is rare beyond 14 days. During this latent period the only complaint, if

any, is mild abdominal pain and nausea but not severe enough to report to a physician.

The actual episode of renewed bleeding and rupture is rapidly climacteric. The dominating feature is one of bleeding which produces shock. Thus, sweating, weakness, and syncope coupled with a rapid pulse and wide pulse pressures are virtually diagnostic. Interestingly enough, the signs of peritoneal irritation are generally absent in that there is no rebound tenderness and no rigidity of the abdominal muscle. These cases are brought to the hospital in rather desperate condition with the obvious signs of shock as described above.

Once again the laboratory signs are protean in nature. Serial hematocrit determinations will generally indicate a slowly decreasing blood volume. However, until there is actual rupture of the capsule of the spleen the hematocrit determinations may be normal. However, if one is aware of the possibility of subcapsular rupture the hematocrit may be below normal range and does not return to normal in spite of the disappearances of the clinical signs.

FLAT PLATE STUDIES

On the flat plate studies there may be an indentation in the greater curvature of the stomach with the left upper quadrant showing an unusual opacity. The colon gas pattern in the region of the splenic flexure may be depressed and intravenous pyelography studies may show some cloudiness overlying the left kidney. Chest signs too are variable in that there may be some supradiaphragmatic atelectasis with a small amount of fluid in the costophrenic angle. Fractured ribs in the left chest posteriorly should make one immediately suspicious of the spleen. Upper gastrointestinal studies are indicated if flat plate studies show shifting of the gastric bubble. Barium enema examination of the colon may show some suggestion of a splenic mass in that the splenic flexure is depressed.

If the physician suspects subcapsular rupture of the spleen, the patient should be followed by careful and frequent physical examinations over a several day period. Should a low normal hematocrit and vague left upper quadrant and posterior chest pain persist, an exploratory laparotomy should be performed. A physician should never apologize for a negative exploration under the circumstances as the discovery of subcapsular rupture of a spleen can prevent catastrophic circumstances. If the subcapsular rupture is not recognized until there is overt bleeding through the capsule into the peritoneal cavity with shock and increased abdominal pain, an immediate exploration should be done and splenectomy accomplished.

CASE ONE

Case one: L. W., a 14-year-old white male, was injured at football practice when "hit in the left side of abdomen by helmet." Patient was apparently struck in left abdomen by a head tackle. Immediately following the injury, patient "became pale and vomited" and complained of upper abdominal pain. However, the pain was not severe and it was not reported to his team physician. After approximately one hour this pain disappeared except for soreness and mild nausea. Twenty-four hours after the injury he was seen by his family physician who diagnosed his condition as "contusion of the abdomen" and advised bedrest and observation. Three days after injury the pain persisted, although still not severe, but he continued to "look pale." There was no nausea or vomiting.

He was admitted to the hospital three days after injury with a diagnosis of contusion of abdominal wall versus subcapsular rupture of the spleen. His pulse and blood pressure were normal and hematocrit 34 mm. A flat plate of the abdomen revealed cloudiness in the left upper quadrant with some displacement of the gastric bubble to the mid-line with displacement of the gas pattern in the splenic flexure of the colon. Intravenous pyelography revealed cloudiness in the left upper abdomen with depression of the splenic flexure of the colon, but no change in the kidneys themselves. Upper gastrointestinal studies then revealed the stomach to be displaced medially as noted on the flat plate.

Twenty-four hour observation revealed persistent left upper quadrant tenderness, and an exploratory laparotomy was performed with a presumptive diagnosis of subcapsular rupture of the spleen. At exploration there was subcapsular rupture of the spleen with approximately 500 cc's of blood in the peritoneal cavity. Splenectomy was accomplished and the patient had a smooth postoperative course.

CASE TWO

Case two: C. W., 21-year-old white male, was admitted to the hospital complaining of pain in his left shoulder and left upper abdominal quadrant. He suffered a blunt injury to the left side of his abdomen and his chest two weeks prior to admission in an industrial accident in which approximately 800 pounds of compressed gas ex-

ploded and threw him about 30 feet. At the time of the accident he was taken to the hospital and observed overnight, no evidence of serious injury was found and he was discharged.

During the ensuing 14 days he complained of vague upper abdominal pain and chest pain but had been up and about and eating with no nausea or vomiting. Approximately four hours prior to admission he developed rather sudden onset of severe left shoulder pain, left costovertebral angle, and upper abdominal pain. At admission he was awake and alert but in rather severe distress. Blood pressure was within normal limits and his hematocrit was 40 mm.

A flat plate of the abdomen revealed some shifting of the stomach bubble medially with "cloudiness in the left upper abdominal quadrant." Intravenous pyelography revealed normal renal function and cloudiness in the left upper abdominal quadrant. Twenty-four hours later a flat plate of the abdomen again demonstrated vague changes in the left flank and upper abdomen suggesting internal abdominal bleeding or fluid accumulation. His chest film was normal.

The patient was observed in the hospital for three days with persistent pain although not severe in the left upper quadrant, the left costovertebral angle, or the left shoulder. There was no nausea or vomiting. On the third day his hematocrit dropped from 40 mm's to 32 mm's. The diagnosis of subcapsular rupture of the spleen was made. Exploratory laparotomy was carried out, and patient was found to have a subcapsular rupture of the spleen with approximately 3000 cc's of blood free in the peritoneal cavity. Splenectomy was performed. The patient had a smooth postoperative course.

These two cases represent the insidious course of subcapsular rupture of the spleen, three days and 14 days after injury. Diagnosis of these cases was made by frequent physical examination, careful observation of the hematocrit levels, and radiological studies. ★★★

Field Clinic (39631)

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FEMININE INQUIRY

Four famous questions which history neglected to record are these:

Mrs. Edison: "Why do you have to make light of everything?"

Mrs. Washington: "Must you *always* be first at everything you do?"

Mrs. Fulton: "What in the world are you so steamed up about?"

Mrs. Betsy Ross: "General, those colors you want, red, white, and what?"

Radiologic Seminar LXXXIII: Neurotrophic Arthropathy of the Shoulder

T. S. MCCAY, M.D.
Jackson, Mississippi

NEUROTROPHIC ARTHROPATHIES are produced by a variety of nerve lesions. The most common lesion leading to this condition is central nervous system syphilis, and approximately 10 per cent of patients with this disease entity will develop neurotrophic joints. Various other conditions which may lead to this condition are syringomyelia, diabetes mellitus, peripheral nerve injury, trauma to the spinal cord and spinal cord tumors.[1]

The basic mechanism leading to the production of a neurotrophic joint is (1) loss of joint sensation and (2) repeated minor trauma of the joint surfaces. With the loss of joint sensation comes relaxation of the supporting structure of the involved joint producing abnormal stress on the articular surfaces which leads to fragmentation and dissolution of the articular cartilage, marginal joint fractures. joint effusions, and hypertrophic repairative processes.

The final result will depend somewhat on the joint involved and the type of repeated trauma to which the joint is exposed, but basically one sees narrowing of the joint space, joint effusion which frequently distends the capsule and contains calcium, fragmentation of the bone ends adjacent to the joint surface, and joint subluxation. Pain is usually a late manifestation of this condition and only develops when the disease places stress on the adjacent ligaments and muscles which have retained some sensory nerve function.[2]

The presented radiograph is that of a 31-year-old colored male who in 1965 was found to have platybasia of the skull with hypesthesia of the left upper extremity and weakness of grip bilaterally. Cervical laminectomy of C1 through C6 with decompression of the foramen magnum was carried out at that time with apparent good result since the weakness and sensory changes did not progress. In November 1968 the patient



Figure 1

presented with swelling in the left shoulder and minimal pain. Physical examination revealed reduction in motion, a fluctuant mass presenting anterio-laterally and minimal tenderness. X-rays revealed fragmentation of the humeral head, bone resorption of the adjacent acromial process of the scapula and the distal clavicle, and a cystic soft tissue mass. As is frequently the case in a non-weight bearing joint, there was no evidence of hypertrophic reparative change and no joint narrowing. ★★★

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From the Radiologic Department of the St. Dominic-Jackson Memorial Hospital.

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Challenge of Disaster

RAYMOND S. MARTIN, JR., M.D.
Jackson, Mississippi

Prompt assessment of casualty handling and treatment procedures was undertaken by conferees representing the American College of Surgeons, U. S. Public Health Service, American Red Cross, and hospitals after the tragic and destructive tornado on Jan. 23 in the Copiah, Smith, and Scott county areas.

The value of radio communication, standing disaster plans, and the triage concept was convincingly demonstrated, as were the substantial services rendered by the National Guard, American Red Cross, and a variety of community service organizations.

At 6:25 o'clock on the morning of Jan. 23, 1969, a 450 mph tornado touched down in "Lewis Quarters," the lumbermill area south of Hazlehurst, Miss. A few agonizing moments later the air was calm, but 48 families were homeless, and 61 more had had appreciable damage to their homes. Shock and confusion followed as 10 lay dead or dying. The wind gathered new velocity to move on to Smith and Scott counties in its path of destruction.

In less than 30 minutes, the drive leading to the Hardy-Wilson Memorial Hospital was clogged with traffic as cars, station wagons, and trucks frantically brought the first of the 288 injured survivors to this 59 bed hospital.

Power and telephone lines were damaged, but the hospital's emergency generator cranked and started. At first only four, but soon 11 physicians joined the administrator in triage of the injured. Efforts to call the University Hospital to evacuate the more serious cases were unsuccessful; however, the University operator was soon able to establish telephone connection that remained open continually for the next few hours.

Seldom do responsible persons in one locale have the rare opportunity to apply knowledge required in one disaster to a similar one in the same area. One week following the tornado, this disaster was studied in depth by Dr. Robert Price, assistant surgeon to the medical director of the United States Public Health Service, together with representatives of the administrative, medical and nursing staffs of the Hazlehurst and Brookhaven hospitals, American Red Cross, and the Trauma Committee of the American College of Surgeons. Recognizing that this tornado was unusually early in the season, an effort was made to ferret out facts from this experience which might be of value to physicians and hospitals throughout Mississippi, one of the prominent states in the "tornado belt."

If one factor could be credited with bringing order out of chaos in this 1969 experience, in contrast to the 1966 Candlestick Park tornado in Jackson, it would be the value of radio communication. In 1966, all telephone communication was lost to south Jackson. Recognizing this vulnerable point, the hospital administrators of the Jackson-Vicksburg area embarked on a hospital short wave radio communications system. One week prior to a scheduled drill, this disaster gave them a full-fledged opportunity for demonstration—and it was successful. Tied in with police radio monitors and wide area telephone service lines, the Jackson area was ready to receive, coordinate, and distribute casualties in an orderly manner.

Hospital administrators plan to continue efforts toward a statewide emergency radio network. The applications of such a system would be limitless. Ambulances and helicopters could be equipped on the same frequency. Commercial radio and television channels could be tied in to route traffic, personnel, and casualties. In the present emergency, radio established and maintained bed

Chairman, Committee on Trauma, American College of Surgeons, Mississippi Chapter.

counts, directed patients to the most effective treatment center, and evenly distributed victims.

It was also useful for identification and reuniting family members separated in the haste of evacuation. Experience gained here suggests that if communications are satisfactory, a large number of casualties can be handled without putting a full disaster plan into effect.

It is frequently pointed out that civilian physicians and surgeons may not be familiar with battle-type wounds. From war to war and from disaster to disaster, these principles must be relearned.

The victims of this destructive storm were literally bathed in a sea of mud. Tree limbs, straw, pine needles, and splinters of wood and shingles were propelled with such force that they penetrated the skin to considerable depths. Lacerations, puncture wounds, and contusions were much more common than fractures. Actually, few casts were applied at Hazlehurst. Only one patient required blood during primary care.

Antibiotics, the sophisticates of civilian practice, cannot replace the principles of good surgical technique. Delayed wound infections are the scourge of mass casualty treatment. Large numbers of dirty lacerations might best be cleaned as well as possible, packed open, and repaired secondarily. The exceptions to this principle would be the wounds of the face and joints.

Prophylactic tetanus immunization is still borderline in Mississippi adults. Human immune globulin was used generously in the Hazlehurst area. It is hoped that forthcoming emphasis on wider use of tetanus toxoid will reduce this need.

The other basics of trauma therapy stressed include primary concern for the patient's airway, judicious treatment of shock, and the time-honored principle of splinting all fractures.

Once again the role of the University Medical Center at Jackson was fully appreciated. Alerted to expect approximately 25 seriously and multiple wounded patients, it was ready! As in Hazlehurst, the casualties seemed to arrive all at once. Actually, only 13 arrived, but among these were five serious head injuries, three of which required craniotomies, four patients requiring tracheostomies, two requiring tube thoracostomy for pneumothorax, and one fracture of the spine.

Specialty teams directed by a triage officer, shock and holding bed areas, operating and recovery rooms were on stand-by to care for these patients. The advantage of the resident house staff and the school of nursing was noted. Though routine hospital procedure was cancelled, the usual emergency room traffic of women in labor, burns, and other accident victims continued to filter through the doors throughout the morning.

The National Guard medical unit was a valuable adjunct as it established and maintained for several days a base at the Hazlehurst Armory. The Red Cross assisted the needs of more than 150 families in the Hazlehurst area alone, with out-of-state personnel continuing their work as long as necessary. They played an important role in assisting the homeless, re-uniting families, and bearing financial burdens where justified. First aid courses provided year in and year out can save several lives in such a disaster and should be vigorously supported. Community rescue programs, as the old volunteer fire department, still have a place, particularly in small communities.

Finally, though there is often a tendency to treat lightly the minutiae required for a good hospital disaster plan, this is the backbone for successful reaction to the crisis of emergency. If this has been thoroughly planned, a hospital can be ready to tackle most any emergency. As in Hazlehurst, pros can arise from the amateur ranks. Skillful triage sorted the patients as they arrived. Adequately trained and disciplined personnel and available supplies met a sudden and urgent need so successfully that instead of hysteria and demand, the patients and relatives reacted with quiet, restraint, and respect for those in authority. Volunteers took over the care of inpatients so that all nursing personnel could be made available.

Even with the satisfaction of an excellent job, the groups represented sought to apply self-criticism to seek methods to improve their own performance. The need for an orange or red fluorescent triage tag to signify immediate priority was expressed.

Individual cases were assessed—were they referred far enough? Too far?

Policemen to control hospital ground traffic should have been assigned early enough to prevent traffic snarl. Concern over transfer of victims from a mass accident scene to the hospital emergency room was expressed. Good as they were, how can communications be improved?

These have been methods to meet the challenge of one disaster. Where will the next one strike? Is that hospital, its administration, and staff ready? Is the population prepared to respond? Only time will tell! ★★★

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The President Speaking

'The Voice of Medicine'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE VOICE OF MEDICINE has become something of a cliché, and it assuredly loses something in translation. This becomes forcefully apparent to each of us in the composition of our boards, councils, and committees in medical organization, whether at county, state, or national level. The cold fact is that we are not genuinely representatives of each specialty discipline, which, of course, includes the largest single segment of the profession, general practice.

It is virtually impractical to structure each committee or constitutional body of any medical society with full and complete representation of the 19 board specialties and general practice. For obvious reasons beginning with size, availability of appointees, and time to devote, almost any committee can at best represent only part of medicine. Your state medical association is aware of this difficulty and has done something about it.

The Board of Trustees, in concert with your general officers, has authorized the organization of an Interdisciplinary Medical Advisory Committee with representation from each organized specialty group in the state.

The committee will be available to the official bodies of the association to advise and assist in communicating the interests and recommendations of the several specialties. The status of the committee will be such as to afford it direct communication to the Board of Trustees and general officers. Obviously, some few specialties which are not organized in state groups may not initially have representation. An example is physical medicine and rehabilitation. But any numerically significant group will be represented. The leadership of the association expects and believes that this action will go far in making our voice less of a cliché and in assuring that nothing is lost in the translation. ★★★

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EDITORIALS

ASH: Mild Label for a Singeing Movement

I

THE NAME understates the case: it's called ASH, a passive label for a vigorously militant organization. The mild acronym fronts for Action on Smoking and Health, a unique Washington-based organization which is carrying the case against tobacco into the federal courts. ASH's weapon is the lawsuit, and it is effectively reaching out to encourage trial lawyers to take up the cudgel against cigarettes.

Sponsored under the leadership of about 30 physicians, attorneys, scientists, educators, and other opinion leaders, ASH is headed by an able, energetic 28-year-old attorney, John Banzhaf, III, formerly of New York. He achieved national prominence two years ago when he successfully pressed a complaint leading to the Federal Communications Commission ruling that broadcasters of cigarette advertisements must furnish "a significant amount of time" to responsible groups with a case to make against smoking.

Describing Banzhaf as "an articulate, to-the-point man," the New York *Times* reports that he organized ASH to monitor radio and TV stations' compliance with the FCC ruling. Now he is broadening the organization's sphere of activity by offering advisory expertise to trial attorneys, filing lawsuits, petitioning executive agencies of the federal government, and undertaking an array of educational activities.

II

Banzhaf has four objectives in mind, says the *Times*. He wants to help those who claim damage to health from smoking to "get the compensation they deserve"; to make tobacco manufacturers pay the bill in court judgments; to force cigarette makers to warn the public of dangers implicit in smoking; and to remind the public again and again that smoking can cause death and disability.

Main vehicle in the four-pronged thrust is a do-it-yourself kit for trial lawyers which ASH will market at cost, now estimated between $100 and $200 each. The kits will be miniature reference libraries of medical reports and papers, legal briefs, court opinions, extensive references, and even lists of expert witnesses.

But the success of the kit project may be riding on a pending decision by the U.S. Court of Appeals for the Fifth Circuit at New Orleans. A three-judge panel of the court reversed a jury verdict in Miami federal district court and held a tobacco manufacturer liable in the cancer death of one Edward Green, Sr. The panel ruled that "under Florida law, the decedent was entitled to rely on the implied assurance that the . . . cigarettes were wholesome and fit for the purpose in-

tended and that under the facts found by the jury, his personal representative and widow are entitled to hold the manufacturer absolutely liable."

When the case was returned to the district court for assessment of damages, the order was set aside for rehearing by the full bench of the appeals court. The crucial ruling is now pending.

III

While a member of a Park Ave. law firm in New York shortly after *magna cum laude* graduation from Columbia University Law School, Banzhaf filed the complaint which resulted in the equal time ruling by FCC in favor of anti-tobacco radio and video spots. In contrast to the cigarette commercials, broadcasters must make the time available without charge. The American Cancer Society and American Heart Association have made notable use of the opportunity with professionally-produced, poignant messages.

Moving on from the courts and FCC, ASH is knocking on the doors of other executive agencies. It is asking FDA's Bureau of Narcotics and Dangerous Drugs to hold hearings and explore a substantial body of respectable evidence that cigarette smoking is addictive.

ASH is filing complaints with the Federal Trade Commission alleging deceptive cigarette advertising, and this action may echo in the halls of the Congress when the law governing tobacco products advertising comes up for renewal during the 91st Congress. When the tobacco-warning measure was initially debated in Congress, many proponents urged mandatory warnings in cigarette advertising. Astutely reading the Congressional pulse, the tobacco industry managed a skillful compromise for the package warning, "Caution: Cigarette smoking may be hazardous to your health." ASH would go much farther.

IV

The weapon of the suit centers around the doctrine of implied warranty. This more or less says that a given thing is what it purports to be or what the maker or seller presents it as being. Often, what is not said about a thing may be just as important as the direct substantive claims made in its behalf.

Since the early 1950's about 70 suits have been filed, chiefly in lung cancer cases, alleging that the manufacturer of cigarettes smoked by the patient or decedent had a degree of responsibility in the condition or death. Less than half a dozen of these cases have ever come to trial, and the Green case is the first in which the plaintiff has apparently prevailed.

While there is little doubt about the end result of tobacco usage, the continuing scientific colloquy over the precise nature of a causal relationship seems to have shown up in the courts as well as in the precincts of the major medical institution and scientific meeting. A decision in the Green suit in behalf of the plaintiff could pave the way for a landmark legal precedent. It simply gets down to the nitty-gritty of legal validation of existing evidence.

ASH and its Mr. Banzhaf may be the crucial quantity in this medicolegal equation. Modestly financed and housed, ASH is already a going thing, as hundreds of radio and television stations can attest. Banzhaf has left his Park Ave. law practice to work out of a two-room suite at George Washington University Law Center where he is also an associate professor.

He speaks of new and different legal precedents which ASH will seek, including suits to establish the right of nonsmokers to be free of cigarette smoke in public places and suits against sale of candy cigarettes to children. Altogether, ASH may just be a pretty mild label for a singeing movement.—R.B.K.

Well Done, SK&F!

A management decision by Smith Kline & French Laboratories has marked the end of an era in postgraduate medical education. The respected specialty manufacturer of ethical pharmaceuticals has discontinued its famous Medical Color Television Unit with a final phase-out date targeted for June 1, 1969.

The unique idea was initiated 20 years ago when black-and-white TV in the home was something which the neighbors came in to see. During the two decades of operation, the SK&F unit gained unequalled expertise in medical TV production technique. The unit staff, headed by Louis W. Crist of Philadelphia, was without peers in organizing, structuring, and presenting useful scientific programs of unusual teaching value.

At the 100th Annual Session of the association, the Scientific Assembly was built around SK&F color TV with program segments originating at the University Medical Center for closed-circuit reception at the headquarters hotel. It was a first and a best in scientific offerings by the association.

The presence of the unit in Mississippi was a direct compliment to Mississippi medicine, because the services were usually and logically re-

served for major national and regional scientific convocations. Nor were these programs confined to the United States, because SK&F sent the unit literally around the world.

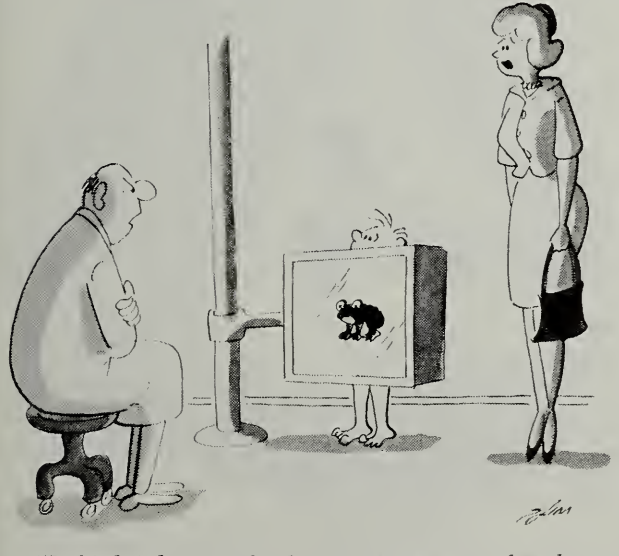
The proliferation of closed-circuit television capabilities has become a fact of the late 1960's with many university centers—including UMC at Jackson—and major teaching hospitals boasting their own systems and facilities. There can be little doubt that the pioneering work of SK&F weighed heavily in many local decisions to acquire this most dynamic of teaching media.

Continuing medical education has been measurably assisted by this contribution, another example of concern on the part of the ethical drug-making industry generally and one of its respected members specifically. The JOURNAL wishes the fine men and women of the SK&F Medical Color TV staff well in their further endeavors and expresses appreciation from the practicing profession for this vital contribution.—R.B.K.

The Tax Challenge for Medicaid

Taxation and tax reform may be the major political and economic issues of 1969. In the Congress, Rep. Wilbur Mills (D., Ark.) says that he will hold hearings before his powerful Committee on Ways and Means on tax reform. Every state is grappling with the knotty problem of tax revenue with little more left to tax and few enough to pay the levy.

Tax revenue lies at the root problem of every major government program in Mississippi where, in the past year, one was solved, one was shelved, and one was gingerly ignored. The 1968 Regular Session of the Legislature passed the $1,000 teacher pay raise and funded the most massive program for the common schools in history. The highway program went down swinging in a constitutional referendum, and Title XIX—Medicaid saw little action.



"I think I know why his voice seems to be changing."

On the surface, federally-assisted programs sound tempting and generous. But even a moderately prosperous state finds the going rough in raising the local 10 per cent for interstate highways and the state shares for federal education and medical care grants.

The Chamber of Commerce of the United States reports that our tax bill is rising beyond belief. The 10 per cent federal income surtax made the most headlines last year, but state and local levies increased, too. The U. S. Chamber says that employed Americans must work two and a half hours out of every eight just to satisfy the tax collector. Many, obviously, work much more of their time to pay taxes.

In 1969, the federal government expects to collect $122 billion in income tax from individuals and corporations. This is not especially encouraging, either from the viewpoints of having to pay the bill or match up the collections to the pending $195.3 billion federal budget.

In 1932, the federal tax take was just over $1 billion. On the eve of World War II in 1940, Uncle Sam collected only $2 billion. By 1950, the take was $26 billion, and two decades later, the inflow is more than quadrupled. Generally, state taxes have more than doubled in the same 20 years.

U. S. Chamber studies show that the median state tax revenue per capita in the nation is $296. A better and more realistic measure is the state tax revenue per $1,000 of personal income. In the latter category, Mississippi is exceeded by only 18 states with an annual tax take of $111 per $1,000 of personal income. It must also be remembered that federal, county, and municipal taxes are in addition to this state bite.

Mississippi is among the top 13 states in sales tax levies of 4 per cent and more, and the same is true of the gasoline tax bracket. In contrast, six states have no sales tax, 13 have no personal income tax, and 10 do not tax corporate income.

For the state with the lowest per capita income in the nation, the tax challenges of 1969, Medicaid and highways, will be a test of the mettle of the administration, the Legislature, and the electorate.—R.B.K.

Moving Mountains: The Paperwork of Medical Care

Almost every busy physician knows that voluntary health insurance and prepayment and government-sponsored medical care programs carry elements of inconvenience. The paperwork burden is not minor nor can it ever be in a $20 billion annual flow of cash. Moreover, it *could* be immeasurably worse than it is today were it not for the Health Insurance Council uniform claim form.

The standard, one-page form carries the endorsement of AMA, every state medical association, and a vast majority of the insurance companies. Through the device of standardization, the form saves millions of dollars in time and effort each year. In Mississippi, it carries the formal sanction of both the Mississippi State Medical and Mississippi Hospital associations. For years, MSMA has made the physicians' form available to members at cost in pads of 25 sets each.

But with 17 out of every 20 Americans covered by some type of voluntary insurance or prepayment and another two covered by a government program, there is valid concern about the paperwork burden, despite standardized and simplified forms. To this challenging matter, we should address some serious thought and imagination.

If somebody had told our grandfathers that they could take a $5 bill and a walletful of credit cards and travel first class around the world, the matter would have been summarily dismissed as a practical impossibility. The late 1960's and 1970's will bring the United States into the era of telecommunications never seen before. Rapidly developing teleprocessing techniques make it possible for *our* computer to talk to *your* computer for the price of a station-to-station long distance call. The telephone companies and computer manufacturers are making the technique inexpensive and effortless as well as deadly accurate.

We may well witness—within the next half a dozen years—insurance claim forms with a tear-off signed blank check which the doctor need only fill out and deposit. Another time saving innovation may be reading a claim for professional compensation over the telephone directly into a computer which coughs out the check for mailing in a matter of seconds.

Still another possibility for assaulting the paperwork problem would be health insurance policies with benefit coupons for its face amount, much like dividend or interest coupons on securities and bonds. The physician might clip the coupon, validate it with a service and identification code and deposit it to his credit at his bank. After all, some physicians now accept bank credit cards in lieu of cash payment or conventional billing for professional services.

All this talk of electronic processing, instant transmission of credit or payment, and the like may leave many physicians with impressions ranging from sheer wonder to frank distaste. The fact of the matter is that mountains of information must be moved, and it is important for the system to work for us, or we will surely be working for the system.

It is also important that the physician-patient relationship be kept inviolate, that each physician continue to have the personal prerogative of establishing the value of his services, that in programs of insurance, repayment, or other benefits, fee review be conducted by a physician's peers within his medical community.

And it can be done, because voluntary health insurance and prepayment were imagination and creativity a generation ago. Physicians can and will contribute immensely in these respects and maintain their voices in the socioeconomic affairs of their profession.—R.B.K.



"She says she knows how you hate false alarms, so she waited until the pains were one minute apart."

The Growing Issue of Abortion Reform

The new legislative season is sure to mark renewed effort to reform state statutes on abortion. At best a controversial subject, the issue is also at worst, a deep problem area with medical, social, moral, and legal roots. As candidly stated by the American Medical Association's House of Delegates two years ago, abortion is a subject of medical interest where physicians possess an acute awareness of the accompanying nonmedical overtones.

For the third time in as many years, New York Assemblyman Albert H. Blumenthal, a Manhattan Democrat, has introduced a bill at Albany to reform the Empire State's 86-year-old abortion law. His bill covers the areas specified by AMA, including danger to health and life of the mother, substantial risk that the baby will be born with mental or physical impairment, or that the pregnancy resulted from forcible rape or incest.

But the new measure goes much farther, so much so, in fact, that it may be as hotly debated throughout the nation as in the statehouse at Albany.

Assemblyman Blumenthal's bill would permit therapeutic abortion when the prospective mother has a mental or physical impairment which would not allow her to care for her child. He further defines forcible rape as also having occurred when the victim is incapable of giving consent or is under 11 years of age.

Regardless of the circumstances of the pregnancy, the Blumenthal measure would permit abortion if the woman is 15 years of age or less and is unmarried.

Written consent by the husband would not be required in cases where continuation of the pregnancy would, in cognizant medical opinion, constitute a hazard to life or health of the woman. The bill strengthens criminal code enforcement by requiring that forcible rape be reported to county law officers or to a licensed physician within 10 days of occurrence.

The Republican-controlled legislature appears to favor the far-reaching measure. In his annual message to the opening session this year, Gov. Rockefeller said that "it is time to relax the rigid statutes under which abortions are performed" in New York. The bill has drawn editorial support from the press and got a big boost from the New York *Times* the day it was introduced.

Whether these unique departures in statute become the law of a sovereign state remains to be seen, but the debate which will inevitably precede final action offers the potential for constructive discussion over a difficult issue.—R.B.K.

Medicine of the 1970's

A favorite subject of the science fiction writers is speculation on the state of a given science a decade or a century hence. And it's not unusual that many of these out-of-the-ballpark novelists have turned out to be conservative. After all, the astronauts have done just about everything Buck Rogers did in a comic strip a generation ago except to whiz around the cosmos with a beautiful girl named Wilma.

At a recent convocation sponsored by Mountainside Hospital at Montclair, N. J., Dr. Stanley W. Olson of the National Institutes of Health offered a number of down-to-earth predictions for medicine in the 1970's. He believes that the "virtuoso performance of the surgeons and their skilled teams" will continue to astound us in organ transplantation.

Dr. Olson sees the problems of this challenging area as being the availability of donor organs and the rejection phenomenon, in that order. As a consequence, he says, we may expect substantial gains in workable artificial organ replacements.

But the medical man will be making concomitant advances in coping "with problems that lie far beyond the surgeon's reach," Dr. Olson feels. He predicts new victories in the laboratory in research for antivirus agents. He says that it may not be as dramatic as the polio vaccines, but it will be dramatic. Expecially does he foresee progress in developing the anticancer agents.

New and special diagnostic techniques are coming in the 1970's, Dr. Olson said. He believes that pathologists will find new ways of measuring abnormalities of the blood and in other body fluids. He sees new diagnostic techniques in amplification of electrical discharge for detecting disease of the heart, brain, and muscles.

Radiology will be usefully complemented by new methods in thermography, ultra sound, and Xerography. He believes that accurate measure can be made of "the distortions produced by infection or tumors." New and better techniques in anesthesia are coming, he says, to the benefit of advancing surgery.

Unlike problems confronting the sciences of nuclear physics and aeronautical engineering which yield readily to the integrated task force approach, medicine stands always on the threshold of discovery in the success of a single investigator. It may just turn out that Dr. Olson was conservative in his estimates.—R.B.K.

POSTGRADUATE CALENDAR

RECENT ADVANCES IN MEDICAL AND SURGICAL MANAGEMENT OF RENAL DISEASES

University Medical Center, Jackson
March 7, 1969

Sponsored by the Mississippi Kidney Foundation, the University of Mississippi School of Medicine Department of Medicine, Division of Urology

Guest speakers will be Dr. Neal S. Bricker, professor of medicine, Washington University School of Medicine, and Dr. Clair Cox, assistant professor of urology, Bowman Gray School of Medicine, Wake Forest University. Other faculty, all from the School of Medicine, will be Dr. Harper Hellems, Dr. Ben Johnson, Dr. John Bower, Dr. Alvin Brent, Dr. Lamar Weems, and Dr. Jose Montalvo.

SIXTEENTH ANNUAL CARDIOVASCULAR SEMINAR

University Medical Center, Jackson
March 26, 27, 28, 1969, beginning at 8:30 a.m.

Sponsored by the Mississippi Heart Association and the University of Mississippi School of Medicine

Participants:

Lionel M. Bargeron, M.D., professor of pediatrics, University of Alabama Medical Center, Birmingham

Denton A. Cooley, M.D., professor of surgery, Baylor University College of Medicine, Houston, Texas

James D. Hardy, M.D., professor of surgery and chairman of the department, The University of Mississippi School of Medicine, Jackson

J. Willis Hurst, M.D., professor of medicine and chairman of the department, Woodruff Medical Center of Emory University, Atlanta, Georgia

Patrick Lehan, M.D., professor of medicine and Mississippi Heart Association Love Memorial Professor of Cardiology, the University of Mississippi School of Medicine, Jackson

George V. Mann, M.D., associate professor of biochemistry, Vanderbilt University School of Medicine, Nashville, Tennessee

Paul K. Peterson, M.D., internist (pulmonary diseases), Houston, Texas

Wednesday Morning

History and Current Status of Organ Transplantation
Dr. Hardy

Cardiac Transplantation in Man
Dr. Cooley

Therapy of Acute Rheumatic Fever
Dr. Bargeron

Pediatric Rounds

Wednesday Afternoon

Cholesterol Metabolism
Dr. Mann

Bedside Diagnosis
Dr. Hurst

Treatment of Acquired Valvular Disease by Valve Replacement
Dr. Cooley

Thursday Morning

The Ecology of Myocardial Infarction
Dr. Hurst

Diagnostic Considerations in the Control of Coronary Disease
Dr. Peterson

The Physiology of Complete Transposition of the Great Arteries and Its Surgical Implication
Dr. Bargeron

Surgery Rounds

Thursday Afternoon

The Overtreatment Syndrome
Dr. Hurst

Evaluation of Functional Capacity and Exercise Tolerance of Cardiac Patients
Dr. Lehan

Discussion

Friday Morning

Exercise and Fitness in Prevention of Coronary Disease
Dr. Mann

The Care of the Critically Ill Infant or Child
Dr. Bargeron

Evaluation of Systolic Murmurs
Dr. Peterson

Medicine Rounds

Friday Afternoon

Center Assembly

Psychological Aspects of Coronary Artery Disease
Dr. Peterson

CIRCUIT COURSES

Physicians in the Meridian area will host their first postgraduate education circuit course March 4. Topics for the 6:30 p.m. dinner meeting at Northwood Country Club are total esophageal replacement and management of malignant melanoma.

EAST CENTRAL CIRCUIT—Session 2

MERIDIAN—April 1
Northwood Country Club, 6:30 p.m.
Current Approach to Tetanus Prophylaxis and Treatment, Dr. Raymond Martin
Evaluation and Management of Auditory Problems in Children, Dr. Godfrey Arnold

SOUTHWESTERN CIRCUIT—Session 3

NATCHEZ—April 15
Jefferson Davis Memorial Hospital, 7:00 p.m.

EASTERN CIRCUIT—Session 3

COLUMBUS—April 22
Aubrey and Ellon's Restaurant, 6:30 p.m.
Peripheral Vascular Disease
Arteriograms, Dr. Hugh McLeod
Surgical Approach, Dr. Thomas Kilgore

FUTURE CALENDAR

March 4

CIRCUIT COURSE, MERIDIAN

March 7

KIDNEY SEMINAR

March 17-21

STROKES AND RELATED NEUROLOGICAL DISEASES

March 26-28

CARDIOVASCULAR SEMINAR

April 1

CIRCUIT COURSE, MERIDIAN

April 15

CIRCUIT COURSE, COLUMBUS

April 22

CIRCUIT COURSE, COLUMBUS

May 6

CIRCUIT COURSE, MERIDIAN

May 12-15

MISSISSIPPI STATE MEDICAL ASSOCIATION

PERSONALS

JERRY R. ADKINS of Biloxi reigned as king during the recent carnival ball in the Coast city. The annual social season highlight is sponsored by the Krewe of Les Femmes. Theme of the 1969 gala was "Kaleidoscope USA."

JASPER B. BECKER, JR., of Brookhaven has announced the removal of his offices to 439 N. Jackson St. in the Medical Arts Building.

GUS A. BYNUM of Hattiesburg has been awarded a life membership in the Optimist Club. He is a past president of the Hub City club and a past lieutenant governor of Optimist International. Presentation of the honor was made recently by incumbent club president Weldon Hatcher of Hattiesburg.

JON C. CAMPBELL and JACK QUIN CAUSEY of Centreville have become full-time associates of the Field Clinic. Dr. Campbell will engage in the general practice of medicine, while Dr. Causey will limit his practice to internal medicine.

MALCOLM W. DAVIS has been appointed chief of staff of the Biloxi and Gulfport facilities of the Veterans Administration Center on the Mississippi Gulf Coast. Dr. Davis is a native of El Dorado, Ark., and he received his medical degree at the University of Arkansas Medical Center. His postgraduate training was received at UAMC and at Pontiac General Hospital, Pontiac, Mich. He is a diplomate of the American Board of Internal Medicine.

JOHN P. ELLIOT, JR., of Tupelo has become a Patron of Excellence of Mississippi State University. Patrons, many of whom are physicians, pledge to support the university with gifts of $10,000 over a period of 10 years. Dr. Elliot is a graduate of MSU, and he received his M.D. from the Tulane University School of Medicine and his postgraduate training on the Tulane service at Touro Infirmary. He limits his practice to urology.

ROBERT N. ERVIN of Gulfport has announced the closing of his Biloxi office which was formerly maintained on a part-time basis. He will continue his practice at 4500 W. Pass Road, Gulfport, where he limits his professional work to neurological surgery.

LOUIS A. FARBER, MCWILLIE M. ROBINSON, JR., and BOBBY G. SPELL, all of Jackson, were

inducted as Fellows of the American Academy of Orthopaedic Surgeons during the society's annual session at New York. A total of 349 Fellowships were bestowed by AAOS in the ceremonies. Certification by the American Board of Orthopaedic Surgery is a prerequisite to election to Fellowship in the Academy.

R. J. Field, Jr., of Centreville recently participated in the 47th Annual Meeting of the American College of Surgeons' Committee on Trauma at Baltimore. Dr. Field serves as regional chairman of the national committee for Louisiana, Mississippi, and Texas. He presided over a portion of the Baltimore meeting.

Benjamin P. Polk, Jr., of Jackson is serving as Mississippi delegate to the American Society of Internal Medicine. He recently participated in a regional meeting of ASIM at Tampa, Fla.

Frank G. Gruich of Biloxi has been elected chief of staff at Howard Memorial Hospital for 1969. Max A. Curry of Biloxi was elected president of the staff. Other officers named are Harry J. Schmidt, vice president; Ervin Joffe, secretary; Felix J. Harrell, Jr., chief of general practice; Warren C. Plauche, chief of ob-gyn; J. Ray Foster, chief of internal medicine; Steve Sekul, chief of pediatrics; and Maurice A. Taquino, chief of surgery. All are from Biloxi.

Clyde Gunn, Jr., of Moss Point reigned at the Cosmos Ball in the east Coast city recently. Benefits from the occasion were given by the sponsors to the National Muscular Dystrophy Fund.

A. V. Hays has been elected president of the Gulfport Century Club. The organization's annual social occasion has been planned for April at the Sunkist Country Club.

Cecil G. Jenkins of Jackson has been appointed Head Start Consultant for Mississippi by the American Academy of Pediatrics. AAP furnishes consultation services under the terms of a contract concluded between the Academy and the U. S. Office of Economic Opportunity.

James M. Packer of Jackson has been installed as president of the medical staff at the Mississippi Baptist Hospital. He succeeds D. T. Brock, Jr., who served as staff president during 1968.

Robert L. Peede of Brandon has begun construction on a new clinic building on North College at Tamberlim St. in Brandon.

Philips A. Sheffield of Fulton has completed a two-year tour of duty as a medical officer of the U. S. Air Force and has returned to Atlanta where he will continue a residency in otolaryngology at Grady Memorial Hospital. He received his M.D. degree at the University of Tennessee College of Medicine in 1965 and completed his internship at the University of Tennessee Research Hospital at Knoxville.

Loutrelle Stribling of Carthage has been appointed to the Board of Trustees of the Leake County Memorial Hospital by the board of supervisors.

A. L. Thaggard of Madden has been named chairman of the Leake County School Board. He is serving his third year on the county board.

David J. Van Landingham of Jackson recently addressed the North Jackson Lions Club on cardiovascular disease. He appeared in behalf of the Mississippi Heart Association.

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

Abney, Robert Luther, III, Jackson. Born Bay Springs, Miss., July 24, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned North Carolina Memorial Hospital, Chapel Hill, N. C., one year; pediatric residency, same, July 1, 1963-June 30, 1967; pediatric cardiology fellowship, July 1, 1967-June 30, 1968; elected Dec., 1968 by Central Medical Society.

Armstrong, William Riddick, Jackson. Born Vardaman, Miss., May 27, 1915; M.D., University of Tennessee College of Medicine, Memphis, 1937; interned St. Anthony Hospital, Oklahoma City, Okla., one year; pediatric residency Children's Hospital, Birmingham, Ala., 1938-39; EENT residency, Underprivileged and Crippled Children's Hospital, Columbia, Mo., 1939-40; Ophthalmology residency New York Hospital, New York City, 1952-54; Ophthalmology-Pathology residency, Armed Forces Institute of Pathology, 1954-55; fellowship Tulane University and Gulf State Eye Foundation, New Orleans, La., 1947-49; elected Dec., 1968 by Central Medical Society.

Barta, Lloyd Leslie, Jackson. Born Wilber, Neb., June 18, 1921; M.D., University of Nebraska College of Medicine, Omaha, 1946; interned McCook Memorial Hospital, Hartford, Conn., one year; residency Charity Hospital, M. D. Anderson Hospital, New Orleans, La., 1949-52; elected Jan., 1969 by Central Medical Society.

Blount, Robert Estes, Jackson. Born Bassfield, Miss., July 21, 1908; M.D., Tulane University School of Medicine, New Orleans, La., 1932; interned U. S. Marine Hospital, New Orleans, La., one year; medicine residency MC, U. S. Army Hospital, Ft. Slocum, New York, July 1, 1933-June 30, 1938; regular medical officer, MC, USA, 1933-1968, Major General; elected Jan., 1969 by Central Medical Society.

Colson, Richard Lorence, Gulfport. Born New Orleans, La., Sept. 29, 1934. M.D., Louisiana State University School of Medicine, New Orleans, 1959; interned U. S. Naval Hospital, Bethesda, Md., one year; obstetric and gynecology residency, Southern Baptist Hospital, New Orleans, La., July 1, 1963-June 30, 1966; elected May 1, 1968 by Coast Counties Medical Society.

Cottrell, Hugh Barnette, Jackson. Born Pickens, Miss., Feb. 22, 1906. M.D., Tulane University School of Medicine, New Orleans, La., 1932; interned U. S. Public Health Service Hospital, Norfolk, Va., one year; M.P.H. Degree—Johns Hopkins School of Public Health, Baltimore, Md., 1935; career officer, USPHS; elected Dec., 1968 by Central Medical Society.

Day, James Randolph, Jackson. Born Laurel, Miss., Mar. 31, 1939. M.D., University of Mississippi School of Medicine, Jackson, 1963; interned University of Texas Medical Branch, Galveston, Texas, one year; pediatric residency July 1, 1964-June 30, 1966; elected Dec., 1968 by Central Medical Society.

Edwards, Charles Mims, Jackson. Born Jackson, Miss., Mar. 16, 1936. M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Southern Baptist Hospital, New Orleans, La., one year; psychiatry residency, University Medical Center, Jackson, Miss., July 1, 1963-June 30, 1966; elected Dec., 1968 by Central Medical Society.

Hubbert, Charles Hughes, Clarksdale. Born Lambert, Miss., Sept. 6, 1938. M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Baptist Memorial Hospital, Memphis, Tenn., one year; psychiatry residency, Mental Health Institute, Cherokee, Iowa, July 3, 1964-Dec. 31, 1964; medicine residency, Baptist Memorial Hospital, Memphis, Tennessee, Jan. 1, 1965-Dec. 31, 1965; psychiatry residency, University of Tennessee, Memphis, Jan. 1, 1966-June 30, 1968; elected Dec., 1968 by Clarksdale and Six Counties Medical Society.

Munn, William George, Mendenhall. Born Mendenhall, Miss., May 28, 1936; M.D., University of Tennessee College of Medicine, Memphis, 1960; interned Brooke General Hospital, Ft. Sam Houston, Texas, one year; residency, same, July 7, 1961-Oct. 17, 1961; elected Jan., 1969 by Central Medical Society.

Nettles, Dexter Conley, Jackson. Born Pike County, Miss., Oct. 30, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1966; interned Miss. Baptist Hospital, Jackson, one year; elected Jan., 1969 by Central Medical Society.

Russell, Jerry Ted, Carthage. Born Carthage, Miss., Dec. 1, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Parkland Memorial Hospital, Dallas, Texas, one year; elected Dec., 1968, by Central Medical Society.

Sanders, James William, Clarksdale. Born Memphis, Tenn., Jan. 29, 1935; M.D., University of Tennessee College of Medicine, Memphis, 1959; interned John Gaston Hospital, Memphis, Tenn., one year; surgery residency, same, July 1, 1964-June 30, 1968; elected Dec., 1968 by Clarksdale and Six Counties Medical Society.

Taylor, Eugene Edward, Natchez. Born Ferridan, La., Nov. 7, 1936; M.D., Louisiana State University School of Medicine, New Orleans, 1961; interned Confederate Memorial Medical Center, Shreveport, La., one year; orthopaedic residency, same, July 1, 1962-Oct. 1, 1966; elected Jan., 1969 by Homochitto Valley Medical Society.

Trunzler, Basil Guice, Natchez. Born Jonesville, La., Mar. 12, 1936. M.D., Louisiana State University, New Orleans, 1961; interned Confederate Memorial Medical Center, Shreveport, La., one year; urology residency, same; elected Dec., 1968 by Homochitto Valley Medical Society.

Young, John Randolph, Jr., Natchez. Born Greenwood, Miss., Aug. 30, 1936. M.D., Tulane University School of Medicine, 1961; interned Charity Hospital, New Orleans, La., one year; otolaryngology residency, New Orleans Eye, Ear, Nose & Throat Hospital, New Orleans, La., July

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cum laude

V.P.
at thirty-two

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With its pronounced calming action, Valium can relieve psychic tension promptly, attenuating its somatic signs and symptoms. Further, Valium is distinctly useful when somatic and depressive symptomatology (secondary to psychic tension) coexist. And Valium is generally well tolerated; in proper maintenance dosage, it seldom dulls the senses or interferes with functioning.

When psychic tension-related insomnia appears, an *h.s.* dose added to the *t.i.d.* schedule helps promote sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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to help relieve psychic tension
and its somatic symptoms

1, 1962-July 1, 1965; surgery residency, Ochsner Foundation Hospital, July 1, 1965-June 30, 1966; elected Dec., 1968 by Homochitto Valley Medical Society.

DEATHS

RUSSELL, JOHN CHARLES, JR., Cleveland. M.D., Tulane University School of Medicine, New Orleans, La., 1936; interned Tennessee Coal and Iron Hospital, Birmingham, Ala., 1937; postgraduate work, University of Tennessee College of Medicine; vice-president Mississippi State Medical Association, 1956-1958; died Jan. 10, 1969, aged 56.

Dr. David Wilson Is New JCAH Member

A California physician, Dr. Reed M. Nesbit of Davis, has been named chairman of the Board of Commissioners of the Joint Commission on Accreditation of Hospitals, according to Dr. John D. Porterfield, director of JCAH.

The Joint Commission is the agency principally charged with the review and evaluation of the quality of hospital service in the U. S. Its member organizations are the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons. Dr. Nesbit represents the American College of Surgeons.

Vice-chairman of the Board of Commissioners is Dr. H. Close Hesseltine of Chicago, who represents the American Medical Association. Dr. Wright Adams of Chicago, representing the American College of Physicians, will serve as treasurer, while Dr. Porterfield will serve as board secretary.

New members of the 22-member Board are Drs. Jack Masur of Bethesda, Md.; Donald J. Caseley of Chicago; and David B. Wilson of Jackson, all representing the American Hospital Association; and John W. Daake, M.D., St. Louis, representing the American Nursing Home Association.

Other members of the Board of Commissioners, and the organizations they represent, are:

American College of Physicians: Drs. Marshall N. Fulton of Providence, R. I., reappointed to three-year term; and John A. Layne of Great Falls, Mont.

American College of Surgeons: Drs. Carl P. Schlicke of Spokane, Wash., and John I. Brewer of Chicago.

American Hospital Association: Drs. Philip D. Bonnet of Baltimore, reappointed to a three-year term; George Graham of Schenectady, N. Y.; Mr. George E. Cartmill of Detroit; and Rev. John J. Humensky, Ph.D., of Lakewood, Ohio. Father Humensky will serve as the first at-large member of the board's executive committee.

American Medical Association: Drs. Richard E. Palmer of Alexandria, Va., and William B. Hidebrand of Menasha, Wis., both reappointed to three-year terms; L. O. Simestad of Osceola, Wis.; Burt L. Davis of Palo Alto, Calif.; Lester H. Rudy of Chicago; and Amos N. Johnson of Garland, N. C.

American Association of Homes for the Aging: Mr. Herbert Shore of Dallas, reappointed to a three-year term.

The American Nursing Home Association and the American Association of Homes for the Aging have been participating members of the Joint Commission since it began accrediting extended care facilities in 1966.

COMING IN APRIL

The special issue of the JOURNAL on the 101st Annual Session, May 12-15 at Biloxi, is scheduled for publication in the first week of April.

The full program of the Scientific Assembly covering two and a half days of general sessions, a dozen specialty societies, and a host of related fellowship, medical alumni, and social activities will occupy a 28 page section.

The special issue will also include reports to the House of Delegates from the Board of Trustees, a number of councils, and various officers.

The special issue will not overlook usual JOURNAL fare, because the publication schedule includes scientific articles and all regular feature departments.

Crunch Is on Part 1-B Expenditures; Bill Seeks Assignments at Shield Rates

A wide array of Washington-centered actions strongly suggest a concerted tightening on government medical care expenditures. New and tougher regulations for Medicare from HEW, a tighter rein on hospital costs, new care delivery patterns, and even a bill in the U. S. Senate to abolish the concept of usual and customary fees figure in the picture.

HEW rules which literally freeze fee profiles for payments under Part 1-B of Medicare, initiated as a parting shot by outgoing Secretary Wilbur Cohen, remain unchanged by HEW officials of the Nixon administration. Subject to finalization, the new requirements would cause delays up to one year in upward professional fee adjustments.

Robert H. Finch, new HEW secretary, is known to have conferred privately with Rep. Wilbur D. Mills (D., Ark.), chairman of the House Committee on Ways and Means, over ways to halt rising medical care costs.

Secretary Finch said later that Rep. Mills' staff and HEW representatives "are going into this to see what we can do about skyrocketing costs, especially hospitalization where 70 per cent of the costs are labor."

Citing a pilot program in his native state of California where he was lieutenant governor in the Reagan administration, Secretary Finch appeared to favor transfer of long-term hospital patients into intensive care centers or super nursing homes.

In a parallel but apparently unrelated action, the majority leader of the Senate, Sen. Mike Mansfield (D., Mont.) was joined by two New England Republicans, Sens. George Aiken and Winston Prouty of Vermont, in sponsoring a bill

CHAMPUS NOT AFFECTED

The state medical association said that the sweeping changes imminent under Part 1-B of Medicare do not affect the Civilian Health and Medical Program of the Uniformed Services under existing federal law. Professional service, allied professional, outpatient, and prescription drug aspects of the program are administered by the association.

There are neither plans nor indications for altering the concept of reimbursing physicians who render services under CHAMPUS. The usual and customary fee concept is employed, based on geographic profiles and not on individual physician profiles. Most badly lagging fee levels have been corrected following the change a year ago from the old maximum fee schedule to the usual and customary concept.

The association reports that about 94 per cent of all billings are being paid as charged under CHAMPUS. This is said to be a higher rate of payments on billed amounts than Part 1-B of Medicare which hovers at the 90 percentile. Of the remaining 6 per cent of billings, about half are processed administratively with communication to the physician concerned. The other half, or 3 per cent of the total, are formally placed before the CHAMPUS Review Committee.

which would abolish payment of physicians under the concept of usual and customary fees.

Instead, the Mansfield-Aiken-Prouty measure would force all physicians rendering services to over-65 beneficiaries under Part 1-B of Medicare to take assignments and be paid at the rate of average payment under local Blue Shield.

If the measure were enacted as introduced and applied literally, it could have the effect of reducing prevailing medical fees as much as 70 per cent when tied to a low-level Blue Shield indemnity schedule.

The bill would also eliminate deductibles and co-pay provisions, relieving beneficiaries of all financial responsibility under Medicare. This provision is strongly supported by most labor unions.

Meanwhile, Rep. Mills was reported as favoring broadened Medicare benefits for the disabled under Social Security. The Johnson administration unsuccessfully sought inclusion of this provision last year.

If enacted, Medicare would be extended to cover the disabled, regardless of age, so long as they had qualified for cash disability payment under Social Security.

Rep. Mills was also reported to be concerned over increases in hospital and physicians' charges in the program.

The record-setting Johnson budget for fiscal 1970, submitted just before the Nixon inauguration in January, calls for $6.9 billion for Medicare and $3 billion for Title XIX Medicaid. This is a combined increase of more than $1.2 billion over fiscal 1969.

HEW says that total government spending for health care last year was $19.4 billion or more than three times as much as the tab of $6.4 billion in 1960 just eight years ago.

The U. S. Department of Labor reports that overall medical costs, including hospitalization and physicians' fees, rose 7.3 per cent in calendar 1968. A rise of the same percentage was reported in calendar 1967.

Some Washington observers note that the crunch on medical care expenditures by the federal government will be made with even greater pressure following former Secretary Cohen's refusal to increase the monthly Part 1-B premium to $4.40 from the present level of $4, the amount charged the beneficiary which is matched by federal appropriation.

State Is 99 Per Cent Brucellosis-Free

Mississippi is the 43rd state to be designated as a modified-certified brucellosis area, the U. S. Department of Agriculture has announced.

Modified-certified status is granted when the incidence of the disease in cattle has been reduced to less than 1 per cent of the animals and less than 5 per cent of the herds in the state.

A certificate designating Mississippi as a modified-certified brucellosis area was presented to Agriculture Commissioner Jim "Buck" Ross by Dr. John L. Wilbur, assistant director, Animal Health Division, of USDA's Agricultural Research Service.

The presentation was made during the recent Dixie National Livestock Show in the coliseum at Jackson.

Mississippi qualified the last of her 82 counties on Jan. 27. Last year, more than 15,000 herds and over 350,000 animals were brucellosis tested to reach this intermediate goal in the drive to eradicate the disease.

Two highly developed surveillance procedures —market cattle testing for beef cows and the brucellosis milk ring test—were effectively used in Mississippi. There are approximately 12 million beef cows and 245,000 dairy cows in the state.

In market cattle testing, cows are identified with backtags when they enter market-slaughter channels. When slaughtered, a blood sample is taken and the identifying backtag accompanies the sample to the laboratory. When infected animals are found, the identified backtag is used to trace the animal to the herd of origin so that arrangements can be made with the owner to eradicate the disease.

For the brucellosis milk ring test, a composite sample of milk from each dairy herd is tested. Mississippi screens all dairy herds in this manner 4 times a year. If the test indicates that brucellosis may be present, all eligible cows in the herd are blood tested to find the infected animals.

The Mississippi brucellosis eradication effort is directed by Dr. Vernon Chadwick of Jackson, state veterinarian, and Dr. L. J. Pate, veterinarian in charge for USDA's Animal Health Division in cooperation with the beef and dairy cattle producers of the State.

Nationally, all but seven states—Louisiana, Florida, Texas, Oklahoma, Nebraska, South Dakota, and Hawaii—have achieved modified-certified status. A record number of counties, 3001 in

the United States, Puerto Rico, and the Virgin Islands, have reached this intermediate goal in eradicating brucellosis.

A total of 1,207 counties is certified brucellosis-free. This total includes all counties in 14 states, Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Maryland, Michigan, Wisconsin, Washington, Nevada, Utah, and the Virgin Islands.

At the present time, all counties in the nation, except nine in Texas and one in Florida, are participating in an organized brucellosis eradication effort. These 10 counties are expected to join the 99.6 per cent that are proving that brucellosis can be eradicated.

Dr. Ochsner Addresses MSU, MSCW Students

A prominent surgeon and medical scientist warned at Mississippi State University that the use of tobacco is the greatest health hazard confronting Americans.

Dr. Alton Ochsner, director of surgery for the Ochsner Clinic and Ochsner Foundation Hospital in New Orleans, spoke as the first in a series of distinguished lecturers sponsored by the C. B. Mitchell Pre-Med Fund at MSU.

"The use of tobacco is responsible for the premature death of 300,000 persons in the United States at the present time, as well as the complete disability of millions of people," he declared.

Dr. Ochsner made 11 appearances at State and MSCW during his two-day visit.

Citing numerous scientific studies, Dr. Ochsner explained that the chance of dying from lung cancer is 81 times greater in chain smokers than in non-smokers.

"The tragedy of cancer of the lung is that it is increasing in incidence more than any other cancer of the body, and except for one rare kind, all cancers of the lung are caused by cigarette smoking.

"Equally as tragic, however, is the fact that the curability rate of cancer of the lung is extremely low."

The former president of the American Cancer Society and the American College of Surgeons, Dr. Ochsner said smoking is also responsible for many chronic respiratory ailments, such as bronchitis and emphysema.

"Emphysema is one of the worst conditions



Dr. Alton Ochsner receives a golden spike, symbol of the C. B. Mitchell Fund, from Dr. John C. Longest at Mississippi State University. Group, from the left, is MSU President William L. Giles, Dr. C. B. Mitchell, Jr., of Meridian, Dr. Ochsner, Dr. Longest, Dr. C. B. Mitchell, Sr., and Dr. Tom H. Mitchell of Vicksburg.

caused by smoking, because some cancers can be cured—but nothing can be done with the patient with severe emphysema except palliation, and sometimes this is so inadequate that the extreme air hunger makes life intolerable."

He also explained that smoking plays a role in the production of heart disease, particularly among young people. He said the risk of developing heart disease is 1.7 times greater in the cigarette smoker than in the non-smoker.

"Mothers who smoke more often have smaller and premature babies," warned the noted physician. "Moreover the infant mortality rate and incidence of abortion are higher."

Dr. Ochsner also said that he was convinced that "patients with ulcers cannot be cured as long as they smoke."

He quoted one research source as saying that for every cigarette one smokes his life is shortened 14.4 minutes. Another study, he said, estimates that one out of every 23 heavy smokers at the age of 35 will be dead before the age of 45, compared with one out of 90 non-smokers.

Dr. Ochsner, who is emeritus professor of surgery at Tulane University, is a charter member of the American Board of Surgery and Board of Thoracic Surgery.

The C. B. Mitchell Pre-Med Fund, sponsor of his visit, was set up last year by MSU medical alumni and friends to enrich pre-medical studies at State. It was named in honor of the man who served MSU for 27 years as college physician.

Heart Monographs Are Published

Three new volumes have been issued in the American Heart Association's Monograph Series. They are "Cardiovascular Surgery 1967," a "Cooperative Study on Cardiac Catheterization" and a "Diagrammatic Portrayal of Variations in Cardiac Structure," reprinted as Numbers 19, 20 and 21 respectively in the series.

"Cardiovascular Surgery 1967," consists of papers presented at AHA's annual Scientific Sessions that year. Edited by C. Frederick Kittle, M.D., the 230-page, paper cover volume contains 31 articles on various aspects of cardiovascular surgery.

The "Cooperative Study on Cardiac Catheterization" assesses the risk of various procedures, provides data to allow reduction of these hazards, and appraises current procedures in use at catheterization laboratories. Edited by Drs. Eugene Braunwald and Harold J. C. Swan, the material was collected by 16 participating laboratories over a two-year period.

Volume 21 is a system of loose leaf diagrams portraying various types of cardiac structure. It is designed as a unique teaching device to clarify variations on intrinsic cardiac structure, variations in relationships between the great arteries and the ventricles, and the significance of a right-sided cardiac apex. The material was compiled by Drs. Paul Stanger, Robert C. Benassi, Michael E. Korns, Kenneth L. Jue and Jesse E. Edwards.

The volumes may be obtained through local Heart Associations or the AHA National Office, 44 East 23rd St., New York, N. Y. 10010.

UMC Names Five to Medical Faculty

Five new appointments this winter have brought the number of full-time University of Mississippi School of Medicine faculty to an all-time high of 129.

Added at the rank of associate professor was Dr. Donald M. Sherline in the department of obstetrics and gynecology. Dr. Sherline received his M.D. degree, interned and completed his residency at Northwestern University. Previously, he was acting medical director, postgraduate medical education program for the Ryukyu Islands, and a postdoctoral fellow at Western Reserve University in Cleveland.

New assistant professor in pharmacology is Dr. Larry T. Welch, who earned his Ph.D. from Vanderbilt in 1967.

Instructors joining the faculty are Dr. Allen Wilson Cowley, Jr., physiology and biophysics; Dr. Jerry W. Cannon, biochemistry; and Edmond Charles Henson, pathology. Dr. Cowley, a UMC Postdoctoral Fellow, earned his M.S. and Ph.D. degrees from Hahnemann Medical College of Pennsylvania in 1968. Dr. Cannon got his Ph.D. degree from Drexel Institute of Technology, Philadelphia, Pennsylvania. Henson holds the B.S. and M.S. degrees from the University of Southern Mississippi and taught at Demopolis, Ala., before coming to the center as a postdoctoral fellow in 1962.

Thoracic Society Conducts Case Meet

The 13th Annual Tri-State Thoracic Society Consecutive Case Conference was conducted at Biloxi on Jan. 10-11 with over 85 chest specialists interested in emphysema, tuberculosis, and other respiratory diseases attending the meeting.

This scientific forum is co-sponsored annually by the Mississippi Tuberculosis Association and the Mississippi Thoracic Society and the Tuberculosis Associations and Thoracic societies of Alabama and Louisiana.

Guest discussants invited to attend the 1969 conference included Dr. Paul A. Kirschner of New York City, associate in surgery, Columbia College of Physicians and Surgeons and associate clinical professor of surgery, Mount Sinai School of Medicine; Dr. Gerald L. Baum of Cleveland, chief pulmonary section, V. A. Hospital; and Dr. William V. Weldon of Birmingham, a radiologist.

The series of cases presented by society members included "Ten Consecutive Cases of Tuberculosis in Children" by Dr. Dwight Keady, assistant superintendent of the Mississippi State Sanatorium, and "Ten Cases of Radiologic Interest" by Dr. Robert Sloan of Jackson, chairman of the department of radiology at UMC.

Dr. G. B. Shaw, Jackson, served as moderator of the Saturday morning session and welcomed delegates on behalf of the society.



Mississippi Thoracic Society members attending the annual Tri-State Thoracic Society Consecutive Case Conference in Biloxi are from the left: Dr. G. Boyd Shaw of Jackson, Dr. Helen Bernfield of Jackson, secretary-treasurer, and Dr. Dwight Keady of Sanatorium.

Other scientific papers included: "Ten Mediastinal Diagnostic Problems" by Dr. Hurst Hatch and Dr. John Ochsner of New Orleans; "Ten Cases of Unusual Pulmonary Edema" by Dr. Morton Brown, Dr. Howard Buechner and Dr. Mortin M. Ziskind of New Orleans; "Ten Consecutive Lung Biopsies" by Dr. Thomas S. Wilson and "Ten Consecutive Cases on Respiratory Failure" by Dr. Durwood Bradley, Jr., and Dr. Dick D. Briggs, Jr., of Birmingham.

Dr. Merrill N. Bradley of Birmingham and Dr. Morton Brown of New Orleans served as moderators of the first and final sessions, respectively. At the noon luncheon on Jan. 11, a paper was presented by Dr. Gerald L. Baum, Cleveland, Ohio.

On April 1, the Mississippi Tuberculosis Association will officially change its name to the Mississippi Tuberculosis and Respiratory Disease Association to coincide with the change of the National Tuberculosis Association a year ago to the National Tuberculosis and Respiratory Disease Association.

The new name will more adequately describe the function and program in which constituent and affiliated associations throughout the country have been involved since 1956.

Sight Society Offers Research Awards

Funds to support pilot research projects will be made available by the National Society for the Prevention of Blindness. The announcement was made by Dr. John W. Ferree, executive director of NSPB.

The Committee on Basic and Clinical Research of NSPB is accepting applications for grants for scientific study which will contribute to the basic understanding of eye function and pathology and improve methods of diagnosis, treatment, and methods for the prevention of blinding eye diseases.

Grants not exceeding $5,000 will be made for a one-year period for projects not being financed by other sources. Renewals may be applied for at the end of the year.

The NSPB Committee asks that all applications be submitted by March 1969, so that they may be considered at its annual spring meeting. Application forms may be obtained by writing to NSPB, 79 Madison Avenue, New York, New York 10016.

The National Society for the Prevention of

Blindness, Inc., founded in 1908, is the oldest voluntary health agency nationally engaged in the prevention of blindness through a comprehensive program of community services, public and professional education and research.

Hospital Workers Sue for Wage Minimums

Thirty-two employees and former employees of the East Mississippi State Hospital at Meridian have filed suit in the U. S. District Court seeking payment of $62,000 under the Fair Labor Standards Act.

The plaintiffs are suing the hospital and the Board of Trustees of State Mental Institutions. The complaint states that the hospital failed to meet minimum wage standards between Feb. 1, 1967, and June 30, 1968. The amount sought in the suit is said to be the difference between wages received and totals due under FLSA minimums then in effect.

AAP Issues Policy on Malnutrition

If protein-calorie malnutrition is to be eradicated throughout the world, the United States must not only distribute surplus foods to developing countries, but more importantly, must help such countries produce and distribute their own food and special food mixtures.

In a statement examining the problem of malnutrition in the world's children, the American Academy of Pediatrics has emphasized that "nutritionally appropriate foods must reach and pervade the usual channels of marketing and distribution in adequate quantities (in underdeveloped countries), so that they can take their place as part of the regular daily diet."

The statement, prepared by the AAP Committee on International Child Health, emphasizes that merely supplying surplus foods to developing countries "is less important in the long run in eradicating malnutrition than other measures aimed at promoting broad technological and social change."

For example, the AAP statement cites the recent development of special food mixtures enriched with high quality protein and appropriate for younger children. "The sources of such proteins are present in countries outside the United States, and industries to produce foods based upon them can be developed more rapidly than a dairy industry," the Academy states.

Excellent guidelines for the development and testing of such products have been prepared by the Protein Advisory Group (PAG) of the World Health Organization-Food and Agricultural Organization-United Nations Children's Fund.

The Academy statement, however, recognizes that human need is such that food from the United States must be shipped to developing countries. When foods produced in America are sent abroad, the AAP urges:

Except in case of emergency, food from the United States should be donated to developing countries only when the food is requested by the country to support or help to initiate a long-range national plan that will eventually result in meeting national food needs, and only if the United States commitment can be firm and unalterable over the time period agreed upon.

Such foods should not interfere with the promotion of normal breast feeding, or compete with local products which are nutritionally satisfactory and available to children.

The nutrients of the foods shipped should be substances presently unavailable to children in quantities needed by them.

The food supplied should be tested for safety, for efficiency in providing for adequate growth, acceptability, and actual use.

Ideally the foods should reach a target population of children under two years of age whose nutritional needs are not being met by breast milk, children who have already experienced some degree of malnutrition, and those who live in areas where malnutrition is most prevalent.

The Academy cited the alarming fact that protein-calorie malnutrition coupled with infection is the greatest killer of infants and young children in today's world. It is also the greatest cause of retarded child growth and development.

"It has been estimated that by 1969 there will be 276 million child victims of serious malnutrition in 29 developing countries," the AAP statement indicates.

The statement further points out that protein-calorie malnutrition is not limited to developing countries, but is also found in the United States, although less frequently than in developing countries.

"Protein-calorie malnutrition in children can be prevented or alleviated," the AAP statement concludes. "Its persistence should not be tolerated by

any nation. Eradication of malnutrition by every means available to society must become a high priority consideration."

Continuing, the statement also concludes that although protein-calorie malnutrition is not a major problem in affluent, technologically advanced societies, "they too must recognize its importance, commit their influence, and allocate sufficient resources to eliminate severe malnutrition among children."

Jury Finds for Laurel Physicians

Four Laurel physicians were unanimously sustained by a trial jury in Jones County Circuit Court in a $99,000 professional liability suit. The jury, consisting of four women and eight men, found for the defendant physicians after deliberating only one hour following the four-day trial.

Completely cleared of the plaintiff's allegations were Drs. H. L. Boone, David I. Carlson, E. E. Ellis, and James C. Waites. The Laurel *Leader Call* reported that the plaintiff was Mrs. Norweida Chapman who sued for loss of a leg by amputation.

The physicians successfully answered the declaration by stating that the amputation was necessary through no fault or negligence of their own and that they, in fact, were able to save the life of the patient.

Solid Wastes Pose Disposal Dilemma

Solid waste disposal is a growing problem, and the State Board of Health wants to do something about it.

The agency has applied for federal funds for preparation of a comprehensive statewide disposal program.

"What used to be a mundane chore has now become a major health problem," says Joe D. Brown, director of the Division of Sanitary Engineering in the State Board of Health.

The reason?

"Packaging is a major reason," says Brown. "Everything comes in a throw-away container now. Most families are filling up two garbage cans a day now, instead of one."

Disposable containers are a convenience for the housewife. Once she throws them away, she is through with them. But the problem is only beginning for those who must dispose.

"Take just one example," says Brown. "The plastic milk bottle. It won't decompose. You can't break it. If you try to compress it, it bounces back. And you can't burn it at a normal temperature."

The throw-away soda pop bottle is another problem. They are thinner and cheaper than the old bottles, so that it's more economical for bottlers to let them go than to pay people to round them up.

Meanwhile, a growing torrent of plastic bottles, throw-away glass containers, aluminum cans and other hard-to-burn and hard-to-break items is pouring from homes into bulging garbage cans.

"We used to talk about garbage," says Brown. "Now we talk about solid waste. With so many garbage disposals in kitchen sinks, we have less garbage. We now have solid items to deal with."

The Congress, in 1965, passed a Solid Waste Disposal Act providing funds to states for studies on how to cope with the problem. Mississippi is the last of the 50 states to utilize the act.

The State Board of Health, designated by the governor as the state agency for drawing up a plan for storage, collection and disposal of solid waste, has applied for planning funds under the 1965 act.

Brown has already drawn up a schedule for a three-year study to be launched whenever the application is approved and funded. He hopes this approval will come within the next few weeks.

"We want to determine the most economical method of disposing of solid waste," says Brown, "and we may find ways that municipalities near each other can develop joint disposal programs to cut costs."

Brown says the three-year study period will be organized so that it can lead smoothly into implementation as soon as the study is concluded—at least as far as existing facilities and laws will permit.

"Solid waste disposal," says Brown, "is a local matter, in the final implementation. It can be only as effective as local laws and local facilities and local determination make it.

"First, there's the problem of storage. The municipality must have ordinances—and must be ready to enforce them. People must use the right kind of containers, so garbage won't litter streets and sidewalks.

"Secondly, as to collection, towns and cities must be willing to buy trucks which may cost more initially but which can, over the years, not only do a better job of picking up and hauling but save taxpayers some money, too.

"And third, you must have proper disposal.

You can't just dump waste in the ravine by the creek anymore. And much of it won't burn—and if it does burn, it pollutes the air."

Municipalities and boards of supervisors, says Brown, are going to have to spend the money necessary to buy modern equipment which can burn the burnable and bury the unburnable solid wastes in a proper manner.

"We hope our three-year study can point the way and give guidance and help to people at the local level," says Brown, "as to the best ways to meet this growing problem.

"As it stands now, we can't haul waste off fast enough. It should not be burned on an open dump. We can't dump it in the river. We've got to either bury the trash and solid waste or dispose of them in a properly-designed incinerator—or use a combination of the two methods."

UMC Researcher Gets MS Study Grant

The Central Mississippi Chapter of the National Multiple Sclerosis Society announced a research grant of $31,755 to Dr. Oliver E. Bell of Jackson, assistant professor of biochemistry at the University Medical Center. He will study the effects of chemical compounds which may play a role in healthy maintenance of nerve-insulating tissue.

The native of Edwards, Miss., will have the grant over a period of 18 months. It is the largest single award granted in the state by the national society which devotes its resources to research in the disease.

Implant Prosthesis Helps Hand Function

A flexible, intramedullary-stemmed prosthesis designed to restore function to hands disabled by rheumatoid arthritis or trauma has been announced by the Medical Products Division of Dow Corning Corporation of Midland, Mich.

For metacarpophalangeal and proximal interphalangeal joint implant arthroplasty, this medical-grade silicone elastomer implant serves to preserve normal joint space relationship during formation of the supportive fibrous joint capsule. The flexible, hinge-like construction helps to maintain proper internal joint alignment with good lateral stability and minimal flexion-extension restriction.

Physiologically nonreactive to bone and surrounding soft tissue the silastic finger joint prosthesis (Swanson Design) is available in eight sizes. The implant is supplied sterile and can be autoclaved in case of contamination.

The durable implants have withstood mechanical test flexing of over 50 million repetitions without evidence of fatigue or fracture and have been developed over a four-year period of experimental and clinical testing.

Coast Auxiliary Unit Promotes Health Careers

Members of the Biloxi-Ocean Springs Woman's Auxiliary sponsored a health careers day last month, inviting junior high school students from classes of four Biloxi area schools. Mesdames John O'Keefe and Steve Sekul participated in the program.

The Auxiliary program included presentation of an AMA health careers exhibit obtained on loan for the occasion. The ladies also plan a health careers scholarship award to a deserving and qualified student in the area.

'Double Doctorate' Will Be Offered at UMC

The Board of Trustees of Institutions of Higher Learning has approved a new academic program offering a combined Ph.D.-M.D. degree at the University of Mississippi Medical Center in Jackson.

The program will offer selected students the opportunity for carefully coordinated study in medicine and in a specialty or scientific subdiscipline in a minimum of 21 quarters. The curriculum combines medical course work and graduate hours in major and minor fields with independent research.

Students will take the basic formal courses within the preclinical and clinical medical curriculum in the academic year and do much of their graduate and research studies during the summer sessions.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, July 13-17, 1969, New York, N.Y.; Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo. E. B. Howard, Acting Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joseph B. Miller, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 1237, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St.. Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, August, October, December, and May 30. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. Edward Pennington, Ackerman, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, March 4, Second Tuesday, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.

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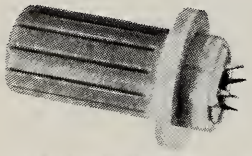
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Manuscripts should be typewritten, double spaced on one side of the paper. Tables, charts, and tabulations should be submitted on separate sheets but their position in the text should be indicated. Authors are encouraged to limit bibliographies to 10 references, written in conformation to style utilized in scientific publications of the American Medical Association. Articles are accepted for publication on the condition that they have not been previously published and are contributed solely to this JOURNAL.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text. Figures and drawings are acceptable when prepared with black ink on white paper. Photographs for illustrations should be unmounted, untrimmed, glossy prints and all such material must be identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

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Index to Advertisers

American Tobacco Co. 102D

Blue Cross **20**
Bristol Laboratories **25**
Burroughs-Wellcome **18A**

Campbell Soup Co. 94A
Ciba Pharmaceutical Co. 102B, 102C

Geigy Pharmaceuticals **8, 9, 10, 18B, 18C, 18F**

Highland Hospital **7**
Hill Crest Hospital **6**
Hynson, Westcott, and Dunning **3**

Kay Surgical **19**

Lederle Laboratories .. **4, 14, 18, 19,** 110A, 110B, 124
Eli Lilly **front cover, 22A, 22B**

Miss. Medical Political Action Committee **23**
McNeil Laboratories 110C

National Drug Co. **14D, 15**

Parke, Davis and Co. **14A**
Pharmaceutical Manufacturers Association 112, **24**
Pitman-Moore 110D, 111
William P. Poythress **14B, 14D**

Riker Laboratories **21, 22**
A. H. Robins Co. **18,** 102A, 114A, 114B
Roche Laboratories
..... **12, 13, 18D, 18E,** 108, 109, **back cover**

G. D. Searle center
Smith, Kline, & French Laboratories **2**
Strassenburgh Laboratories 94D

Warner-Chilcott Laboratories 106A, 106B
Winthrop Laboratories 14C
Wyeth Laboratories **16, 17**

Thomas Yates and Co. **11**

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April 1969



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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CONTENTS

ORIGINAL PAPERS

Bronchogenic Carcinoma: Changing Concepts of Management With Irradiation **125** BERNARD T. HICKMAN, M.D., and ARTHUR E. PARKER, M.D.

A Clinical Comparison of Rectal Pyrilamine Maleate and Trimethobenzamide Hydrocholoride for Control of Vomiting in Children **130** R. C. TIBBS, M.D.

ANNUAL SESSION

Complete Program **133** Four Days in May

Handbook of the House of Delegates **161** Advance Reports

EDITORIALS

Group Practice: Pattern of the Future? **165** Types and Characteristics

Medicine Under Attack: Contradictions **167** *Time* Magazine Blast

Ole Miss Grows Pot **167** Legal Weed for Research

Medical Schools and Tax Support **168** Operating Costs Up

THIS MONTH

The President Speaking **164** Must We Be Last?

Medical Organization **177** Gift of a Hospital

Meetings **176** The 101st and Others

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Otolaryngology Federates New Council

The American Council of Otolaryngology, a new medical organization, has been incorporated in the District of Columbia to represent the patient care interests of the nation's estimated 6,000 otorhinolaryngologists.

The new council, which will establish a national office in Washington this year, plans to provide leadership for national, regional, state and local groups in otolaryngology in order to provide better patient care in this specialty field.

Dr. Jerome A. Hilger of St. Paul, Minn., has been elected chairman of the board by the organizing committee. The other officers elected to the Council are Drs. John E. Bordley of Baltimore, vice chairman; Paul H. Holinger of Chicago, president; Walter P. Work of Ann Arbor, Mich., vice president, and Jack R. Anderson of New Orleans, secretary-treasurer.

A general assembly will be created by the council to provide a "grass roots forum" in which the individual is heard. Provision will be made for representation in this assembly of supporting otolaryngologic societies and academies on all levels, regardless of size.

First national body to represent all of otolaryngology exclusively, the council will help in the development of national programs for improved patient care, more education and further research. In effect, it will serve as a national voice for otolaryngology.

The council will concern itself with the national health problems in its specialty field. It will keep abreast of and seek ways to met national manpower needs of the specialty in both medical and paramedical categories.

Another objective of the new council is to assist training programs at the residency and postresidency levels. At the same time, it will encourage strong programs for continuing postgraduate education in the specialty.

Cooperative liaison with communities and organizations on national and state levels will be undertaken by the council to stimulate better programs for patient care. The council will also assist state and local communities in health legislation relating to its specialty field.

Dr. Hilger, chairman of the board, is clinical professor of otolaryngology at the University of Minnesota Medical School. He is president of the Triological Society; president-elect of the American Academy of Ophthalmology and Otolaryngology, and immediate past chairman of the Ad-

visory Council for Otolaryngology of the American College of Surgeons.

Dr. Bradley, vice chairman of the board is Andelot professor of laryngology and otology at the Johns Hopkins University School of Medicine. He is also professor of environmental medicine, division of audiology and speech at the Johns Hopkins University School of Hygiene and Public Health. He is national consultant in otolaryngology to the Surgeon General of the Air Force.

Dr. Holinger, council president, is professor of bronchoesophagology, department of otolaryngology at the University of Illinois College of Medicine. He is chairman of the Interspecialty Committee of the American Medical Association, and a Regent of the American College of Surgeons. Dr. Holinger was former chairman, Board of Governors, the Institute of Medicine of Chicago, and former president of the Illinois Division, American Cancer Society.

Dr. Work, council vice president, is professor and chairman of the department of otorhinolaryngology at the University of Michigan. He is also president of the American Board of Otolaryngology.

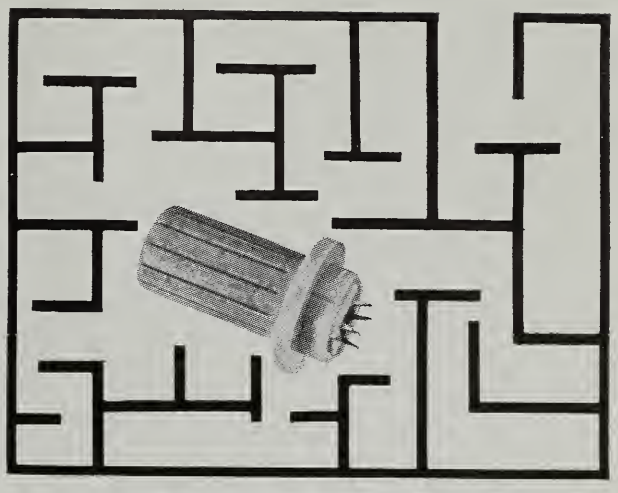
Dr. Anderson, secretary-treasurer, is associate editor of the AMA *Archives of Otolaryngology* and secretary of the American Academy of Facial Plastic and Reconstructive Surgery. He is a member of the department of otolaryngology at Tulane Medical School, and former chief of otolaryngology, independent service at the Charity Hospital in New Orleans.

Equipment Gift Goes to Nigeria

The Mississippi Baptist Hospital has made a gift of a $1,700 operating room light to the Eku Baptist Hospital on the Niger River delta in Nigeria. The gift was made following a visit to Jackson by Dr. Robert Amis, director of the 120-bed general medical and surgical facility operated by the Foreign Mission Board of the Southern Baptist Convention.

Dr. Joel L. Alvis, Jackson urologist, spent a month last year in volunteer service at the Nigeria mission hospital with Dr. Amis, and he has stressed the need for volunteer physician services in mission hospitals throughout the world.

Well-prepared for his work in the medical missionary field, Dr. Amis is a Fellow of the American College of Surgeons.



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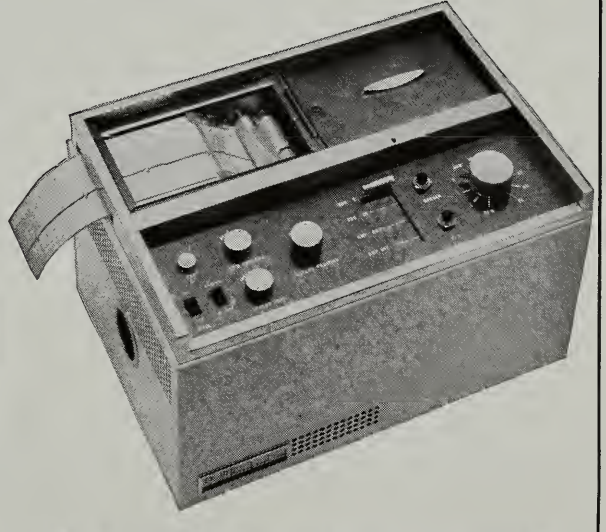
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

April 1969

Dear Doctor:

The State Board of Optometry has filed suit against the State Board of Health over provision of eyeglasses to school children. Complaint seeks injunction to end discrimination alleged by optometrists after medical examination of child to determine presence or absence of eye pathology. Law gives patient choice of optometrist or ophthalmologist.

> Action also joins all members of State Board of Health individually as well as some staff members. Attorney General's office says suit is similar to a 1957 action filed in Forrest County which never came to trial.

AMA Board of Trustees may act this month to appoint a new Executive Vice President. Although selection criteria say that new chief need not be a physician, most observers believe that designee will be an M.D. It is also believed that former salary of $100,000 per year will not be offered. Dr. E. B. Howard, veteran of 23 years AMA service as second ranking executive, has been acting EVP in interim.

Signs of blood supply crisis are showing up in state legislatures in bills to ease squeeze and circumstances of transfusion services. Arkansas, Florida, Montana, and N. Dakota have bills to abolish labeling of blood by race. Kansas and Washington have bills to permit persons over 18 to give blood without parents' consent.

Chiropractors continue to zero in on Part 1-B of Medicare with a wave of bills in the 91st Congress. To date, 23 measures have been introduced in House and one in Senate to provide payment for chiropractic services under Medicare. HEW opposes bills, and most observers believe there is little chance of favorable action.

AMA has established a Registry on Adverse Reactions Due to Occupational Exposure and is requesting reports from physicians. Information on health problems apparently related to work environment or toxic exposure is desired - not reports of accidents and injury. Reports may be sent to Department of Occupational Health at Chicago office.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Alabama Seeks Funds For School Of Optometry

Montgomery - The University of Alabama has asked the legislature for $3.8 million to construct and operate a school of optometry. Proposal is opposed by state medical association as unnecessary and unwise. Shortage of ophthalmologists in Alabama is conceded, but state association says that even doubling number of optometrists will not alleviate M.D. eye specialist shortage. Proponents of optometry school argue that it will improve eye care in state.

Civil Commitment Of Addicts Is Reported Successful

Bethesda, Md. - The National Institute of Mental Health reports that 450 narcotic addicts have been committed for examination or treatment under the Narcotic Addict Rehabilitation Act of 1966. Law considers addiction an illness rather than a crime, and commitment is a civil action, since addicts who have committed crimes are ineligible. NIMH also assumes responsibility for aftercare to be given in addict's home community after discharge from institution.

Visits To Physicians Decline

New York - The Health Insurance Institute says that Americans are seeing their doctors on fewer occasions than they did 10 years ago. Studies show that the typical American saw his physician 4.3 times in 1968, against 4.7 times in 1958. Report also said that a person over age 65 sees doctor six times annually, while youngsters under 15 have less than four visits a year. Home calls have steadily dwindled in favor of consultations at clinic or office.

Indiana Abolishes Charitable Immunity

Indianapolis - The Indiana State Supreme Court has struck down the doctrine of charitable immunity which formerly protected hospitals and other charitable institutions from liability for negligence. In ruling similar to other states, Indiana court said that the doctrine was ill-conceived and had outlived any usefulness which it may have had. Citation is Harris v. Y.W.C.A, 237 N.E. 2d 242 (Ind., 1968).

Government Plans Massive Rubella Immunization

Washington - The federal government is planning a five-year nationwide, massive immunization program against rubella, contingent on licensure of a vaccine. Merck has a vaccine, the HPV-77 strain, said to be 95 per cent effective in tests. PEPI, Inc., has a modified live virus strain, and four other manufacturers are expected to complete work soon on vaccines.

Announcing the New Mississippi State Medical Association $12,500 CATASTROPHE HOSPITAL PLAN

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Flying Physicians Set NY Meet

The 15th Annual Meeting and Lecture Series of the Flying Physicians Association will be held June 15-20 at the Lake Placid Club, Essex County, New York, it was announced at FPA Headquarters.

Officials expect over 700 persons to attend the five-day meeting. Arrangements are being made to handle 250 private aircraft at nearby Lake Placid Airport.

As in the past, this year's meeting will emphasize the FPA's primary objective of promoting general aviation safety through example and teaching.

Dr. Robert L. Wick, Jr., of Columbus, Ohio, is program chairman. Top authorities in aviation safety and aerospace medicine will address the doctor-pilots.

During round table discussions, members will exchange views and experiences on such subjects as instrument flying, weather, and maximum aircraft performance.

Their wives, many of whom serve as co-pilots, will also meet to compare their own flying experiences.

In addition, registrants will be able to view the latest in medical and aviation products and to become more proficient as pilots through a special flight instruction program. A number of manufacturers' aircraft will be on static display at the airport and others will also be available for demonstration flights. Dr. E. Addis Munyan of Lake Placid is chairman of the local arrangements committee.

A portion of this year's program will be devoted to highlighting the samaritan activities of the FPA. An increasing number of members are volunteering to serve in humanitarian projects throughout the world.

The current FPA president, Dr. Neal C. Hamel of Encino, Calif., is completing a three-month tour with Project Hope in Colombo, Ceylon, Dr. John R. and Dr. Vera M. Finlay of Byram, Conn., recently completed a similar tour and president-elect, Dr. Curtis Caine of Jackson, Miss., is now in Viet Nam as a volunteer physician under the auspices of the AMA.

Founded in 1954 by a handful of doctors, the FPA has grown by leaps and bounds. Today, the organization has some 2,000 members and is international in character. Every state is represented and members also reside in Mexico, Puerto Rico, South America, the West Indies, Australia, West Germany, and the Republic of the Congo.

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Governor Reactivates Council on Aging

Governor John Bell Williams has reactivated the Mississippi Council on Aging, naming 13 Mississippians for new terms. E. D. Kenna of Jackson, prominent businessman and a former director of the Highway Department, is council director.

H. J. Massie of Jackson, former director of the old Council on Aging and more recently with the Vocational Rehabilitation Division, is assistant director. Travis McCharen of Jackson, director of vocational rehabilitation, is chairman of the council.

Except for two members of the legislature and two who include a physician, all council members are heads of state agencies, it was noted. Included among the latter is Dr. Frank J. Morgan of Jackson, assistant state health officer.

Dr. A. V. Beacham of Magnolia, former director of the Alcoholic Beverage Control Division of the State Tax Commission, was named to the council.

The announcement said that the re-activated agency would be funded under the Older Americans Act of 1965 through HEW.

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Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

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4. Emphysema

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Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

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NLN Forms Health Agency Group

Formation of an Assembly of Home Health Agencies has been announced by the National League for Nursing, New York. The assembly is sponsored by the League's Council of Public Health Nursing Services to extend its activities in the improvement of care of people in their homes.

More than 2,000 home health agencies which have been certified by the Social Security Administration to receive Medicare reimbursements have been invited to participate in the assembly.

An initial mailing elicited interest in participating in the assembly from more than 1,000 of these agencies.

Services will include periodic communications on subjects of interest to home health agencies and institutes and workshops held in conjunction with regular council meetings. Through the council the assembly will also have a mechanism for interagency relationships with other national organizations functioning in the health care field.

The NLN Council of Public Health Nursing Services, one of six agency member councils in the League, is composed of visiting nurse associations and nursing units of health departments. Many of these are certified home health agencies.

Many other home health agencies have developed outside the pattern of public health nursing. Since to be certified they must include nursing care in the home among their services, the council has initiated the assembly to coordinate communications and to share the expertise and experience of public health nursing agencies with other agencies providing care in the home.

The National League for Nursing is offering this assistance to home health agencies through its Council of Public Health Nursing Services as a part of its program to improve nursing services and nursing education. NLN is a membership organization composed of some 21,000 nurses, allied professional persons, educators, nursing service administrators, community health planners, and interested citizens as well as 1,800 agency members representing nursing services and schools of nursing.

Its activities include accreditation of community nursing services and nursing education programs, publications, research, evaluation, consultation, and conferences.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1969, Vol. X, No. 4

ORIGINAL PAPERS

Bronchogenic Carcinoma: Changing Concepts of Management With Irradiation

BERNARD T. HICKMAN, M.D., and
ARTHUR E. PARKER, M.D.
Jackson, Mississippi

THE MANAGEMENT of primary lung cancer with irradiation is presently undergoing a re-evaluation. With the advent of supervoltage radiation, and particularly with the popularity of Cobalt-60 teletherapy within the last 10 to 15 years, there was hope that some cases of bronchogenic carcinoma which were inoperable or incompletely resected might be salvaged. With this modality of therapy it became possible to increase the dosage of radiation to the tumor without significant damage to the skin or surrounding tissues.

It soon became apparent, however, that merely being able to increase the dosage to the tumor was not the answer to increasing survival. Efforts were then put forth to increase the effects of irradiation by administering ancillary chemotherapeutic agents. This again failed to increase the survival rates. Preoperative and postoperative irradiation were offered in a further effort to alter survival rates, but again without significant results.[1]

The University of Maryland group used preoperative irradiation in the early 1950s with orthovoltage therapy. It was abandoned due to increased operative complications with increased morbidity. This was revived with the advent of supervoltage therapy (i.e. Cobalt-60) and Bloedorn[2] *et al.*, Paulson[3] and others,[4] did some commendable work. It has been found, however, that preoperative irradiation may not play as great a role in the management of primary lung cancer as in the management of cancers that have a greater tendency toward local recurrence rather than widespread dissemination.[5]

From the Department of Radiotherapy, University of Mississippi School of Medicine.

The role of radiotherapy in bronchogenic carcinoma is being reevaluated and seems to be of greatest use in palliation rather than increasing the survival rate. A short rapid course of radiotherapy appears to have as much promise as a prolonged course for this purpose. Statistics from the University of Mississippi School of Medicine are presented.

The Veterans Administration analyzed the 30-month survival of a random selection of patients treated with preoperative irradiation followed by surgery versus a group treated by surgery alone and found that those receiving irradiation had a 5 per cent survival while those receiving surgery alone had a 9 per cent survival. Death from bronchogenic carcinoma is more likely to be from distant metastasis than from local recurrences of the primary tumor. The Veterans Administration

found that in 3,500 autopsies performed on patients who died from bronchogenic carcinoma, 80 per cent of the cases with oat cell, anaplastic or adenocarcinoma had disseminated metastasis while almost 30 per cent of those with epidermoid carcinoma had widespread disease.[6]

A difficulty of offering preoperative irradiation is that it often must be given without a histological diagnosis. To do a pre-irradiation biopsy would defeat the purpose of the irradiation. Not knowing what you're treating until the time of surgery several weeks later could produce hazards such as disseminating a tuberculous or fungus disease or irradiating a benign or metastatic lesion. It seems that preoperative irradiation for lung cancer probably plays its greatest role in those small epidermoid lesions that would be considered resectable preoperatively.

POSTOPERATIVE PALLIATION

Irradiation is administered postoperatively mainly for palliation, not for prophylaxis or to increase the survival rate. One false hope frequently expressed by the surgeon after failing to completely excise all of the tumor is that "a little radiation may sterilize any residual tumor left behind."[7] Nothing could be further from the truth. The surgical procedure itself, when the incision transects the tumor, has a chance of disseminating the malignancy.[8] Local postoperative irradiation, then, would be too late to affect the disseminated disease. The oxygenation of a tumor affects its radiosensitivity, and if a tumor's oxygen (blood) supply has been interfered with surgically, the tumor will be less sensitive to irradiation.

Moss states that if there are reasons to offer postoperative irradiation, the tumor should have been irradiated preoperatively.[9] In spite of this, many surgeons feel that their patients should be given the benefit of any doubt, and the mediastinal nodes irradiated prophylactically if all of the peripheral tumor was thought to have been resected.

Irradiation is not a benign process. With the advent of supervoltage therapy (i.e. Cobalt-60) there is little or no skin damage which leads to the false assumption that the irradiation is causing no significant underlying harmful effect. Most radiotherapists, when treating malignancy in the mediastinum, will give dosages in the range of 5000-6000 rads. These doses are high enough to cause mediastinitis, radiation pneumonitis and subsequent fibrosis with its sequelae, possible damage to the coronary vessels, and possible transverse myelitis of the cord. One should con-



Figure 1a. Bronchogenic carcinoma showing massive atelectasis.

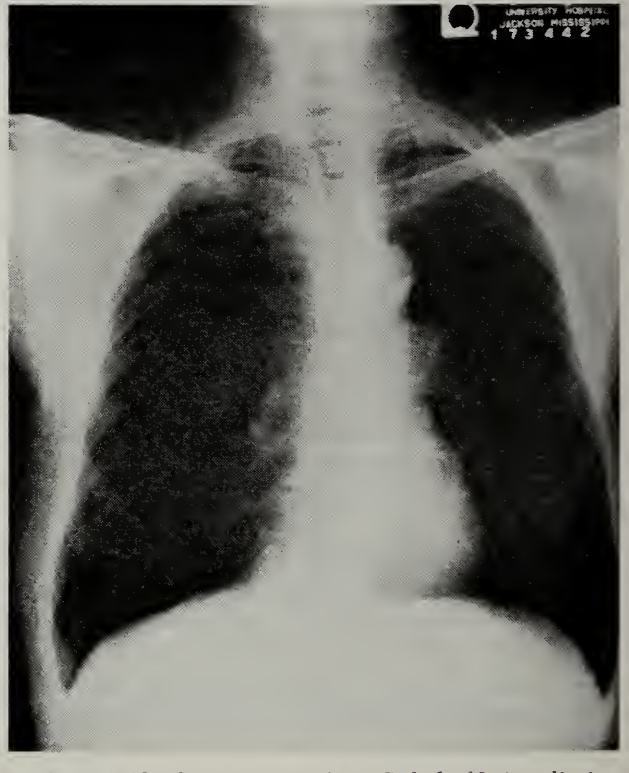


Figure 1b. Same case after Cobalt-60 irradiation to the left hilum.

sider if the possibility of producing these entities is justified by increasing the survival rate. This has not been demonstrated.

Most lung cancers are squamous cell in type and theoretically should be curable by irradiation. The nature of the disease, however, makes this difficult. The lung itself does not tolerate high doses of irradiation well, and most important, the cancer has already spread beyond the site of origin in about 80 per cent of cases by the time the diagnosis is made. In those cases not amenable to surgical resection of the tumors, irradiation does have a significant role to play in palliation and occasionally will cause an increase in the life span.[10]

CONTROL OF HEMOPTYSIS

Hemoptysis can be controlled by irradiation in about 75 per cent of the cases. Local pain due to bone involvement and invasion of the pleura or mediastinum can often be controlled by local irradiation. However, pain due to involvement of the chest wall and nerve trunks is seldom relieved by irradiation. Pain due to distant bone metastases can often be dramatically relieved by short, high dose courses of radiation localized to the area of involvement.

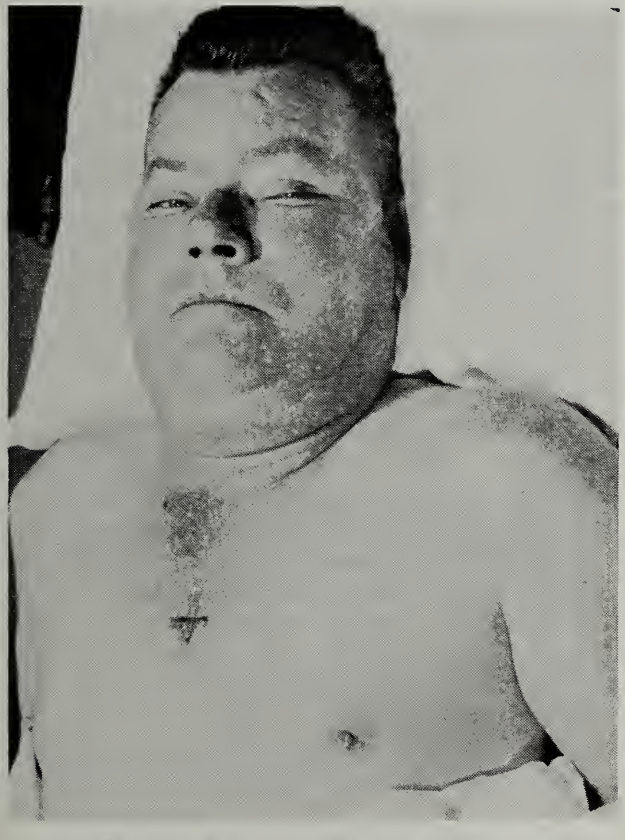


Figure 2a. Patient with superior vena cava syndrome due to bronchogenic carcinoma.

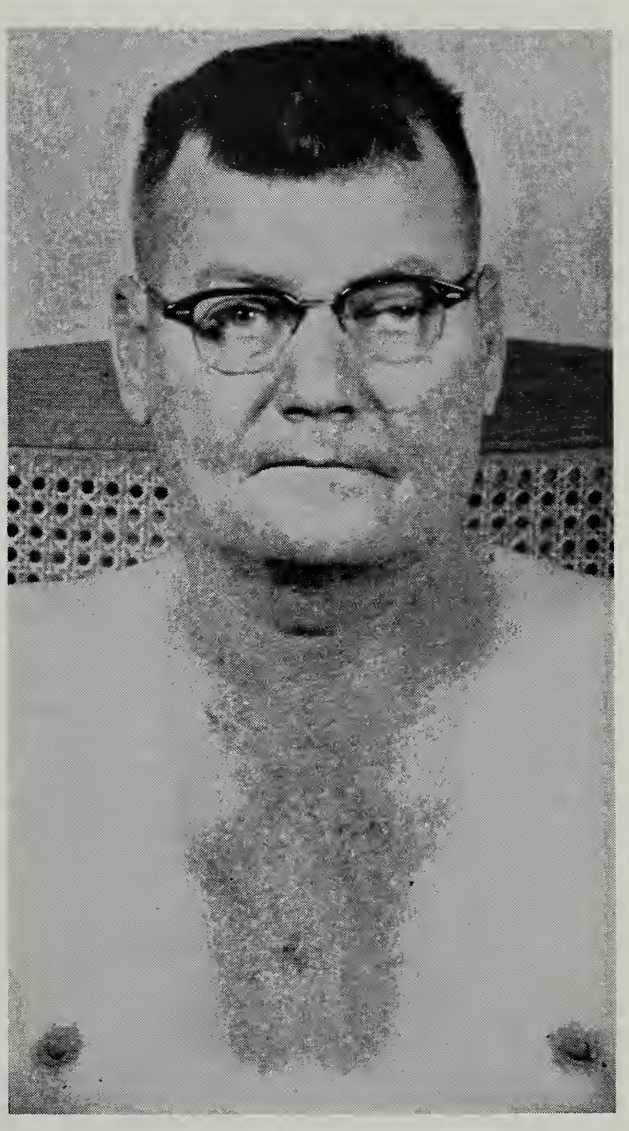


Figure 2b. Same patient after Cobalt-60 irradiation to the superior mediastinum.

Obstruction and atelectasis caused by bronchial obstruction can often be relieved by local irradiation to the site of obstruction (see Figure 1). However, when the lung is infiltrated with tumor, the resultant dyspnea is seldom relieved by irradiation and may be made worse.[11] Superior vena caval syndrome caused by bronchogenic carcinoma is dramatically relieved in about 75 per cent of cases, especially those cases of undifferentiated carcinoma (see Figure 2). However if thrombosis has occurred, relief of the obstruction will often not be forthcoming. Nitrogen mustard may relieve the symptoms sooner, but they usually recur. While it may require three to four days for irradiation to achieve results, relief is usually lasting.

The Radiotherapy Department at the University

Medical Center furnishes the radiotherapy service for the local Veterans Administration Hospital as well as the University. During the 10-year period running through March 1966, there were 628 patients admitted with a diagnosis of bronchogenic carcinoma. Three hundred sixty-five of the patients (58 per cent of the total) received irradiation therapy. The two-year survival rate of the patients receiving irradiation was 7.4 per cent. In most series, the percentage of patients surviving five years is about half of the two-year survivals; so this figure merely shows a trend.

ALTERATION OF SURVIVAL RATE

This survival rate is greatly altered by the number of patients in the series who were operated on and were considered to have had their lesions surgically resected. Of the 21 two-year survivors in our series, 13 were in this category. As is shown in Table I, the resected cases comprised only 10 per cent of the total number of cases, but 34 per cent of them survived two years. One speculates as to whether the postoperative irradiation actually offered any increase in percentage survival

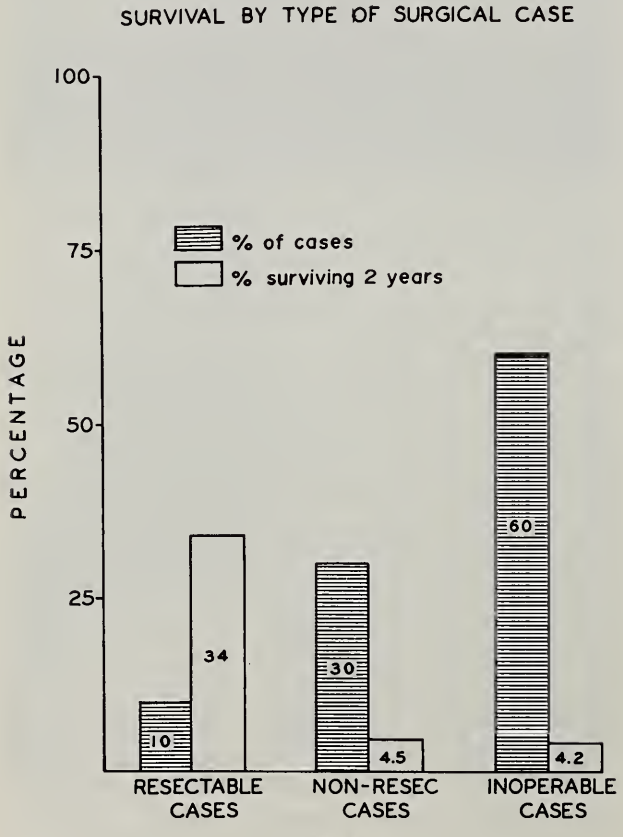


TABLE I

for this group.[12] Sherrah-Davies reporting from the Christie Hospital fails to show any significant change from surgery alone.[10]

Table II indicates that most of the patients referred for radiotherapy were considered to be inoperable. Also, by far the largest histological group was the squamous cell carcinoma. Table III shows that the best two-year survival rate according to histological types is also the squamous

HISTOLOGICAL TYPE OF CASES IN EACH SURGICAL CATEGORY

	INOPERABLE	NON-RESECTABLE	RESECTABLE
SQUAMOUS CELL	104	69	26
ANAPLASTIC	53	24	8
OAT CELL	28	10	1
ADENOCARCINOMA	7	8	3
PAP. IV	24		
TOTAL	216	111	38

TABLE II

cell carcinoma. However, an interesting finding is manifested in Table III. Although oat cell carcinomas comprised only 10.6 per cent of the total cases irradiated, they had the second highest two-year survival rate with 7.1 per cent. It has long been felt that oat cell carcinomas are difficult to cure by any means, but that irradiation offers significant palliation in these cases and that surgery has little to offer. It is also interesting to note that none of the patients with adenocarcinomas treated with irradiation survived for two years. It has been felt for several years that irradiation played no significant role in the management of adenocarcinomas of the lung.[13]

LARGE VS SMALL DOSES

Krant suggested in early 1966 that small doses of irradiation (approximately 2000 rads) may offer as much palliation for lung cancer as large doses. Cook reported in Augst 1968 on 332 cases that were given split-dose irradiation therapy. Dosages of 2000-2400 rads were administered, then the cases were observed for about a month and sometimes the dosage was repeated. His overall two-year survival rate was 8.5 per cent, which compares favorably with other methods of radiotherapy.

We feel that the only sure method of curing bronchogenic carcinoma is adequate surgery. Al-

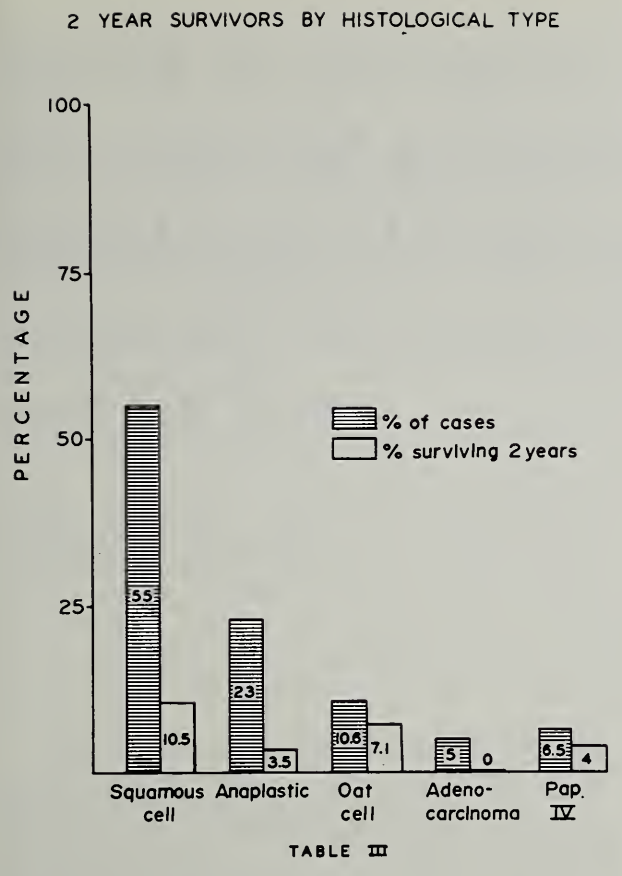


TABLE III

though an occasional patient may be cured by radiotherapy alone, we feel that the prime use of irradiation in lung cancer is in palliation. If palliation is all we hope to offer, it seems an injustice to confine a patient five or six weeks for a long course of radiation therapy when a short course given in 10 treatments can offer the same results.[14, 15] We now advocate giving a tumor dose of 2500 rads in 10 treatments and then have the patient return in one month for re-evaluation. If he shows significant improvement, a repeat similar course of irradiation is given. If there has been no improvement or if there is actual worsening of the patient's physical state, then no further radiation is offered and the patient hasn't been inconvenienced by wasting his time unnecessarily.

Other conclusions are that preoperative irradiation for bronchogenic carcinoma has little to offer. Irradiation seems to play no significant role in the management of adenocarcinoma of the lung, but probably plays the major role in palliation of oat cell carcinoma.[13] ★★★

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CAUTION OF CONTEXT

A mother active in the P-TA visited her daughter's class in junior high school. As the teacher welcomed her to the class, she cautioned in a whisper: "If you should happen to hear the girls discussing the pill, please don't be alarmed—they're just talking about me."

—JIMMY WARD, JACKSON *Daily News*

A Clinical Comparison of Rectal Pyrilamine Maleate and Trimethobenzamide Hydrochloride for the Control of Vomiting in Children

R. C. TIBBS, M.D.
Cleveland, Mississippi

BECAUSE VOMITING may be symptomatic of a serious disorder, such as pyloric stenosis, intestinal obstruction, organic nervous system disease or acute peritonitis, the cause should be carefully sought. In children, vomiting is often secondary to an acute febrile illness. Since it is the most common cause of dehydration in infants and very young children, symptomatic therapy is justified, and a number of products are currently available for this purpose.

Cone[1] described the use of promethazine suppositories in 150 children, 100 of whom had acute nonspecific gastroenteritis. Children less than five years of age were given 12.5 mg. suppositories; 25 mg. doses were used in older children. There was no vomiting after the first dose in 77 per cent; there were from one to four episodes after one dose in 13 per cent of patients; and in 10 per cent there were more than four vomiting episodes. There were no toxic effects. Almost all of these children slept for four to six hours after each suppository.

In an earlier, long-term study, Daeschner, *et al.*,[2] evaluated the effects of chlorpromazine, meclizine, cyclizine, secobarbital, and placebo in a total of 252 patients over a period of two and one-half years. Oral, rectal and parenteral routes of administration were used, depending on the drug. Chlorpromazine was far more effective than either secobarbital or placebo in a double-blind segment of this study. Generally, the antiemetics were not effective when vomiting was primarily due to coughing. Drowsiness, which was seen in about one of three patients, was rarely excessive or undesirable.

We have compared the antiemetic effect of the pyrilamine maleate-pentobarbital rectal insert used in this study with that of promethazine in 60 children.[3] The pyrilamine-pentobarbital combination reduced the number of vomiting episodes 87 per cent during the first four hours of therapy.

Sixty children selected from private pediatric practice were used in a study of pyrilamine maleate and trimethobenzamide hydrochloride in the control of vomiting. The author reports his methods and results and presents a short review of the literature.

Promethazine hydrochloride reduced the number of episodes 20 per cent during the first four hours. The reduction was statistically significant (P .001) on the pyrilamine-pentobarbital combination, but not on promethazine. There were no side effects of any consequence attributable to the use of either preparation.

The present study was undertaken to obtain additional comparative data on the clinical effects of the pyrilamine maleate-pentobarbital rectal insert.

Sixty children were selected from private pediatric practice for study. A careful history and physical examination, along with the indicated laboratory procedures, established that vomiting

was secondary to gastroenteritis, pharyngitis or tonsillitis in nearly every case. To reduce the possibility of including infants with early pyloric stenosis or food intolerance, we limited our patients to those over 14 weeks of age. There was only one exception, a two-month-old girl with gastroenteritis who received trimethobenzamide. We also excluded children with severe diarrhea or evidence of dehydration, as well as those who could not be adequately treated as outpatients. The infants and children included in the study were alternately assigned to one of the two test preparations as they were presented for treatment.

The pyrilamine-pentobarbital rectal insert (Emesert) was used in two dosages sizes. Fifteen patients received one size containing 25 mg. of pyrilamine maleate and 30 mg. of pentobarbital. The other 15 patients were given inserts containing 50 mg. of pyrilamine maleate and 45 mg. of pentobarbital. In the vast majority of cases the parent was instructed to administer the rectal insert, regardless of dosage size, every four to six hours.

Trimethobenzamide hydrochloride (Tigan) was supplied in the form of 200 mg. suppositories. Eleven children received the entire suppository (200 mg.), while 19 patients were given one half the suppository (100 mg.). In nearly every case the drug was administered every four to six hours.

A comparison of the two groups of patients is presented in Table 1.

TABLE 1

DESCRIPTION OF PATIENTS

	Pyrilamine-Pentobarbital	*Trimethobenzamide*
Total number	30	30
Boys	12	12
Girls	18	18
Age range	5 mos.-9 yrs.	2 mos.-10 yrs.
Diagnoses		
Pharyngitis	6	2
Gastroenteritis	8	12
Tonsillitis	10	11
Other	6	5
Average duration of symptoms before treatment	45 hrs.	42 hrs.
Average number of vomiting episodes/24 hours before treatment**	7.43 ± 1.81	7.30 ± 2.46*

* The difference between these averages is not statistically significant.

** Average number vomiting episodes ± standard error.

Each parent was given a standard form on which to record the number of suppositories used, the number and time of any further vomiting episodes, and any comments they might have concerning the response.

Twelve patients on the pyrilamine-pentobarbital combination did not vomit again after the first dose. Fifteen of those on trimethobenzamide hydrochloride also showed complete control with the first dose.

VOMITING EPISODES

There was a total of 18 vomiting episodes in the remaining 18 patients who received the combination, and 29 episodes in the remaining 15 patients on trimethobenzamide. Thus, none of the patients on the pyrilamine-pentobarbital combination vomited more than once after the start of therapy. Four of those on trimethobenzamide vomited more than once (two patients experienced five episodes, and two others had four episodes).

When there were multiple episodes on trimethobenzamide, vomiting persisted for 12 to 24 hours after the start of therapy. In contrast, only one patient on the pyrilamine-pentobarbital combination vomited more than four hours after the first dose. This patient, a 2½-year-old girl with an acute upper respiratory infection, vomited about nine hours after the first dose, when she had a coughing attack.

The average number of vomiting episodes ± standard error during the 24 hours after the first dose was 0.60 ± 0.50 in the pyrilamine-pentobarbital group and 0.97 ± 1.50 in the trimethobenzamide group. There is no statistical significance to the difference between these averages for the entire 24-hour period post-treatment.

During the 24 hours immediately prior to therapy with the pyrilamine-pentobarbital combination there was a total of 243 vomiting episodes. This is an average of 0.34 episodes per hour. During the first four hours after the initial dose there was a 59 per cent reduction to 0.14 episodes per hour. Similar calculations in the patients on trimethobenzamide show a reduction of 45 per cent (from 0.31 to 0.17 episodes per hour). These findings suggest that the response to the combination was more rapid than it was to trimethobenzamide.

While no statistical significance could be assigned to the differences between the two preparations, both produced pronounced clinical benefits in controlling vomiting. This is reflected in the graphic presentation and pre- and post-treatment averages in Figure 1.

There were no side effects of any kind in either group of children.

In an earlier report[3] we described an 87 per cent reduction of the number of vomiting episodes during the first four hours following the pyrilamine

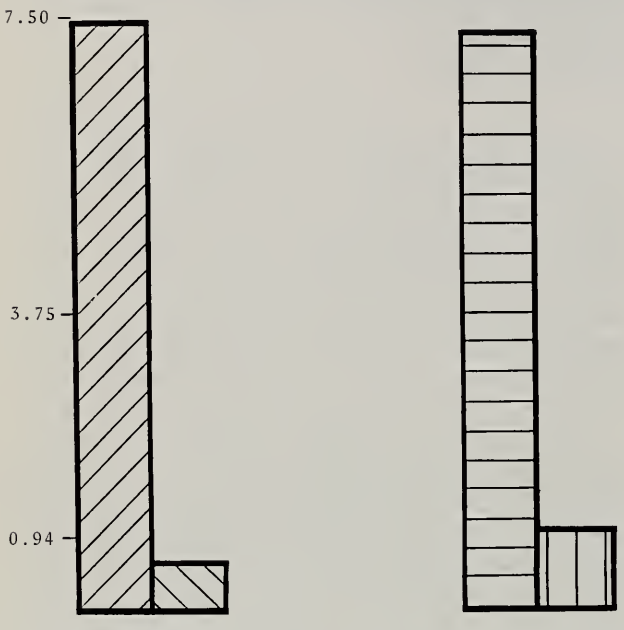


Figure 1. Average number of episodes in 24 hours pre- and post-treatment with left bar showing pre-treatment (to value scale 7.50) with pyrilamine-pentobarbital and post-treatment (lesser portion) with the same agent. Right bar shows pre-treatment (to greater value scale) with trimethobenzamide, and lesser portion shows post-treatment with this agent.

maleate-pentobarbital rectal insert. This reduction was greater than that obtained with promethazine suppositories (20 per cent) to a statistically significant degree. The clinical efficacy of the combination was further confirmed by the results of the present study. In the patients on the pyrilamine-pentobarbital combination there was a 59 per cent reduction in the frequency of vomiting during the first four hours of therapy, compared with a 45 per cent reduction in the patients on trimethobenzamide. While the difference may not be statistically significant, it does suggest a more rapid response to the combination.

In experience with the pyrilamine maleate-pentobarbital rectal insert, we have not encountered any significant side effects. Sedative effects, which were beneficial, have been seen in a few patients. On the basis of the findings to date, we conclude that the pyrilamine-pentobarbital combination is of significant clinical value in the management of vomiting in children.

SUMMARY

Sixty children were selected from private practice to compare the effects of pyrilamine maleate-pentobarbital rectal inserts with those of trimethobenzamide suppositories in the control of vomiting. Following a careful history and physical examination the patients were separated into two groups.

Twelve of the 30 children on the pyrilamine-pentobarbital combination did not vomit again after the first dose, and none of the remaining children in this group vomited more than once during the first 24 hours of therapy. Fifteen of the children receiving trimethobenzamide hydrochloride did not vomit again after the first dose, but the remaining 15 children in this group experienced a total of 29 episodes during the first 24 hours.

When the pre-treatment frequency of vomiting is compared with that during the first four hours following the pyrilamine-pentobarbital combination, a 59 per cent reduction (0.34 to 0.14 episodes/hr.) was found. On trimethobenzamide the reduction was 45 per cent (0.31 to 0.17 epsiodes/hr.).

There were no significant side effects on either preparation. On the basis of these, and previously published, findings we conclude that the pyrilamine maleate-pentobarbital combination is of demonstrable clinical value in the management of vomiting in infants and children. ★★★

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101st Annual Session

Mississippi State Medical Association
May 12-15, 1969
Biloxi

MISSISSIPPI'S SUNNY Gulf Coast becomes the state's medical mecca May 12-15 with the convening of the 101st Annual Session. Six general scientific sessions involving the seven scientific sections, a dozen specialty groups, four medical alumni occasions, technical and scientific exhibits, and a host of fellowship events will be compressed into the four-day meet. Headquarters is the Buena Vista Hotel and Motel complex where the House of Delegates meets May 12 and 15.

Dr. Joseph B. Rogers of Oxford, association president, will address the opening meeting of the House. Speaker William E. Lotterhos of Jackson and Vice Speaker John B. Howell, Jr., of Canton said that reports and resolutions will be presented at the opening meeting, also. Final actions on business will come at the Thursday, May 15, meeting when 1969-70 officers are elected by the delegates.

At the adjourned meeting, Dr. James L. Royals of Jackson will be inaugurated 1969-70 president.

Dr. Walter H. Simmons of Jackson said that the Scientific Assembly will be in session Tuesday, Wednesday, and Thursday morning. Dr. Simmons heads the group which plans, organizes, and programs the annual session. He added that the combined scientific and technical exhibits will offer 70 presentations. Specialty societies will be meeting concurrently with the Scientific Assembly.

The Woman's Auxiliary will conduct its 46th Annual Session, also headquartering at the Buena Vista, according to Mrs. Paul B. Brumby of Lexington, president of the ladies' group. Mrs. Louis C. Lehmann of Natchez will be inaugurated 1969-70 Auxiliary president at the meeting. Mrs. J. Hurd Gaddy of Gulfport is general chairman for the ladies' annual session, and Mrs. Raymond F. Grenfell of Jackson is co-chairman.

Medical alumni from Ole Miss, Tennessee, Tulane, and Vanderbilt have scheduled social occasions on May 12 and 13. The annual association party, featuring a Bourbon Street theme from the New Orleans French Quarter, will pre-empt all Wednesday evening occasions.

Technical and scientific exhibits will be presented in the Buena Vista's Hurricane Room adjacent to all general sessions.

The Buena Vista is confirming reservations in both the renovated hotel and motel. Members are encouraged to make early requests for Buena Vista accommodations. The association also holds room blocks in the nearby Tradewinds and White House for latecomers and overflow requests.

OFFICIAL CALL

To all members of the Mississippi State Medical Association:

The 101st Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Monday, May 12, 1969, pursuant to Article V of the constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Hotel Buena Vista on May 12.

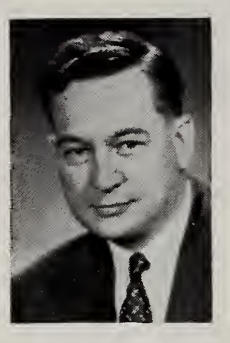
The Scientific Assembly, consisting of the general sessions, will meet during May 13-15, 1969.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

JOSEPH B. ROGERS
PRESIDENT

WALTER H. SIMMONS
SECRETARY-TREASURER

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ACTIVITIES CALENDAR

REGISTRATION

General registration for the Scientific Assembly and House of Delegates will be located in the Hurricane Foyer of the Buena Vista Hotel. No person will be admitted to any activity of the annual session without first registering. The Secretary's Office will be located in Rooms 142-144. Hours of registration will be 2:00 p.m. to 4:00 p.m., Sunday, May 11, 8:00 a.m. to 5:00 p.m., Monday, Tuesday and Wednesday, May 12-14, and 8:00 a.m. to 2:00 p.m., Thursday, May 15.

SUNDAY, MAY 11, 1969

1:00 p.m. Miss. Association of Pathologists, Poolside Room

MONDAY, MAY 12, 1969

7:00 a.m. Reference Committees Breakfast, Sun Room
9:00 a.m. House of Delegates, Fountain Terrace
9:00 a.m. Miss. Association of Pathologists, Card Room
9:00 a.m. Miss. Commission on Hospital Care, Gold Room South
12:00 noon Miss. Orthopaedic Society Luncheon, Sun Room
12:00 noon Flying Physicians' Association Luncheon, Fiesta Room
12:00 noon Woman's Auxiliary Executive Committee Brunch, Poolside Room
1:30 p.m. Miss. Urological Society, Card Room
2:00 p.m. Reference Committee on Reports of Officers and Board of Trustees, Fountain Terrace
2:00 p.m. Reference Committee on Miscellaneous Business, Gold Room Center
3:30 p.m. Reference Committee on Medical Practices, Gold Room
3:30 p.m. Council on Constitution and By-Laws, Fiesta Room
4:00 p.m. Ole Miss Medical Alumni Business Meeting, Poolside Room
7:00 p.m. Ole Miss Medical Alumni Fellowship Hour and Banquet, Motel Pool Area

TUESDAY, MAY 13

7:30 a.m. American College of Ob-Gyn Breakfast, Card Room
7:30 a.m. Scientific Film Session, Hurricane Room E
8:00 a.m. Woman's Auxiliary Past Presidents' Breakfast, Poolside Room
9:00 a.m. General Scientific Session, Hurricane Room E
9:00 a.m. American College of Surgeons, Sun Room
11:30 a.m. Miss. Ob-Gyn Society Luncheon, Poolside Room

12:00 noon Fifty Year Club Luncheon, Card Room
12:00 noon Woman's Auxiliary Luncheon, Fountain Terrace
12:30 p.m. American College of Surgeons' Luncheon, Gold Room South
12:45 p.m. Scientific Film Session, Hurricane Room E
2:00 p.m. General Scientific Session, Hurricane Room E
5:30 p.m. Vanderbilt University Medical Alumni Fellowship Hour, Poolside Room
5:30 p.m. Tulane Medical Alumni Fellowship Hour, Sun Room
6:30 p.m. Miss. Radiological Society Dinner, Gold Room South
6:30 p.m. University of Tennessee Medical Alumni Fellowship Hour and Banquet, Fountain Terrace

WEDNESDAY, MAY 14

7:30 a.m. MSMA Past Presidents' Breakfast, Poolside Room
8:00 a.m. Woman's Auxiliary Continental Breakfast, Gold Room South
8:00 a.m. Scientific Film Session, Hurricane Room E
9:00 a.m. Woman's Auxiliary General Session, Gold Room South
9:30 a.m. General Scientific Session, Hurricane Room E
12:00 noon Mississippi Society of Internal Medicine Luncheon, Sun Room
12:00 noon Mississippi Psychiatric Society Luncheon, Poolside Room
12:00 noon Mississippi Academy of General Practice Luncheon, Fountain Terrace
12:30 p.m. Scientific Film Session, Hurricane Room E
1:30 p.m. Nominating Committee, Card Room
1:30 p.m. General Scientific Session, Hurricane Room E
2:30 p.m. Woman's Auxiliary Post-Convention Executive Board Meeting, Gold Room South
4:00 p.m. Diabetes Association of Mississippi, Sun Room
6:30 p.m. Bourbon Street Party, Fountain and Gold Rooms

THURSDAY, MAY 15

8:30 a.m. Scientific Film Session, Gold Room South
9:00 a.m. Scientific Film Session, Hurricane Room E
9:30 a.m. General Scientific Session on EENT, Gold Room South
10:00 a.m. General Scientific Session on Pediatrics, Hurricane Room E
12:00 noon Mississippi EENT Association Luncheon, Sun Room
1:30 p.m. House of Delegates, Fountain Terrace

EXECUTIVE BUSINESS



DR. LOTTERHOS

HOUSE OF DELEGATES
Monday, May 12, 1969
9:00 a.m.

Buena Vista Hotel
Fountain Terrace
William E. Lotterhos
Jackson, Speaker

John B. Howell, Jr.
Jackson, Vice Speaker



DR. HOWELL

MEETING OF THE HOUSE

The meeting will be opened by the President, and the Speaker, in presiding over the House, will announce the order of business. An open session, Monday, May 12, 1969, to which all members and Auxiliary members are invited will feature the Address of the President, Dr. Joseph B. Rogers. The adjourned meeting of the House will convene in the Fountain Terrace Room at 1:30 p.m. on Thursday, May 15.

REFERENCE COMMITTEES

Reports of Officers and Board of Trustees, Monday, May 12, Fountain Terrace, 2:00 p.m.

Miscellaneous Business, Monday, May 12, Gold Room Center, 2:00 p.m.

Medical Practices, Monday, May 12, Gold Room South, 3:30 p.m.

Constitution and By-Laws, Monday, May 12, Fiesta Room, 3:30 p.m.

Nominating Committee, Wednesday, May 14, Card Room, 1:30 p.m.

THE SCIENTIFIC ASSEMBLY

COUNCIL ON SCIENTIFIC ASSEMBLY

WALTER H. SIMMONS, CHAIRMAN



DR. SIMMONS

THE COUNCIL

JOHN C. SUARES, Chairman, EENT
JAMES K. WILLIAMS, JR., Secretary

HARDY B. WOODBRIDGE, JR., Chairman, GENERAL PRACTICE
W. JOHNSON WITT, Secretary

JOHN R. SHELL, Chairman, MEDICINE
C. RALPH DANIEL, JR., Secretary

OTIS B. WOOLEY, JR., Chairman, OB-GYN
J. PURVES MCLAURIN, JR., Secretary

WALLACE S. SEKUL, Chairman, PEDIATRICS
WILLIAM F. SISTRUNK, Secretary

STEVEN L. MOORE, Chairman, PREVENTIVE MEDICINE
FRANK J. MORGAN, JR., Secretary

DAWSON B. CONERLY, JR., Chairman, SURGERY
M. BECKETT HOWORTH, Secretary

SCIENTIFIC AND TECHNICAL EXHIBITS

THE BUENA VISTA HOTEL

MEDICAL MOTION PICTURES

CALVIN T. HULL, Chairman

CONDUCT OF THE SCIENTIFIC ASSEMBLY

The order of exercise, papers, and discussions as set forth in the official program shall be followed until completion. All papers read before the association shall become its property. Each paper must be read by its author and deposited with the Secretary (or Chairman) when read.

THE SCIENTIFIC EXHIBIT

Physicians, foundations, and organizations will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award, given for excellence of presentation, quality of content, and originality. Others may not participate in the competition, but they are eligible to receive recognition for outstanding presentations. The Scientific Exhibit is located in Hurricane Room D, the Buena Vista Hotel.

EXHIBITORS

"Surgical Treatment of Coronary Artery Disease"
Thomas L. Kilgore, M.D., Jackson

"Permanent Pacemakers: Without Thoracotomy or General Anesthesia"
William R. Fain, M.D.; Carlos M. Chavez, M.D.; H. H. Timmis, M.D.; J. T. Davis, M.D.; and J. H. Conn, M.D., Jackson

"Valvular Heart Disease: Surgical Treatment"
Charles W. Pearce, M.D.; Robert L. Hewitt, M.D.; and Rudolph F. Weichert, III, M.D., New Orleans, Louisiana

"Thoracic Aortic Aneurysms: Surgical Treatment"
Charles W. Pearce, M.D.; Robert L. Hewitt, M.D.; and Rudolph F. Weichert, III, M.D., New Orleans, Louisiana

"A Demonstration Stroke Center—Problems and Benefits"
A. F. Haerer, M.D.; Robert D. Currier, M.D.; Robert R. Smith, M.D.; and W. A. Spencer, M.D., Jackson

"A New Antihypertensive Agent: Double Blind Evaluation"
Raymond F. Grenfell, M.D.; and William C. Holland, M.D., Jackson

"Myocardial Revascularization"
Hector S. Howard, M.D.; and H. Edward Garrett, M.D., Memphis, Tennessee

"Surgical Correction of the Cicatricial Alopecias"
Dowling B. Stough, III, Hot Springs, Arkansas

"The Artificial Kidney in Acute Kidney Failure"
John D. Bower, M.D., Jackson

"Unusual Lesions of the Mediastinum"
J. T. Davis, Jr., M.D.; Carlos M. Chavez, M.D.; James D. Hardy, M.D.; and J. Harold Conn, M.D., Jackson

"A Long Acting Phenothiazine and Treatment of Schizophrenics"
Robert M. Ritter, M.D., Whitfield

"The Key to Their Future"
Mississippi Association for Children with Learning Disabilities

"Intravenous Demand Permanent Pacemakers in Community Hospitals"
Henry B. Tyler, M.D.; and Albert L. Meena, M.D., Jackson

"Progress Through Professionalism"
Mississippi Association of Medical Assistants

MEDICAL MOTION PICTURES

As an extension of the program of the Scientific Assembly, selected medical motion pictures will be shown in conjunction with the general sessions. The schedule follows. Coffee and rolls will be available at the morning programs.

Tuesday, May 13

7:30 a.m. Hurricane Room E
"Modern Management of Pregnancy in the Rh Negative Sensitized Woman"
"Intrauterine Fetal Transfusion"
"Modern Management of Multiple Births"

12:45 p.m. Hurricane Room E
"The Transplanters"
"I Dress the Wound"

Wednesday, May 14

8:00 a.m. Hurricane Room E
"Differential Diagnosis of Chest Pain"
"Physical Diagnosis-Endocrine Disease"

12:30 p.m. Hurricane Room E
"The Mechanism and Control of Nausea and Vomiting"
"Endoscopic Examination of the Abdomen"
"Ultrasound in Medicine"

Thursday, May 15

9:00 a.m. Hurricane Room E
"Nursery Sepsis"
"Nephrosis in Children"
"Examining the Well Child"
"Resuscitation of the Newborn"

8:30 a.m. Gold Room South
"Roundpupil Intracapsular Cataract Extractions"
"Tucking of the Superior Oblique Muscle Tendons"
"Surgical Rehabilitation of the Atrophied Mandible in Preparation for Denture Prosthesis"

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1969 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, equipment, and in providing varied services will present exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The Technical Exhibit is located in the Hurricane Room, the Buena Vista Hotel.

EXHIBITORS	BOOTH
Abbott Laboratories, North Chicago, Ill.	7
ASR Medical Industries, Lukens Division, St. Louis, Mo.	14
Atlas Chemical Industries, Inc. Pasadena, Calif.	21
Automated Management Systems, Jackson, Miss.	37
Ayerst Laboratories, New York, N. Y.	12
Bedsole Surgical Supply Co., Mobile, Ala.	17
Bristol Laboratories, Syracuse, N. Y.	11
Carnation Company, Los Angeles, Calif.	13
Ciba Pharmaceutical Products, Inc. Summit, N. J.	4
Coca-Cola Company, Atlanta, Ga.	45
The EMKO Company, St. Louis, Mo.	5
Imperial Fashions, Los Angeles, Calif.	46
J. Hugh Knight Instrument Company, New Orleans, La.	50
Kay Surgical, Inc. Jackson, Miss.	33
Lanier Company, Jackson, Miss.	23
Massachusetts Mutal Life Insurance Co., Jackson, Miss.	15
McNees Medical Supply Co., Jackson, Miss.	3
M. D. Electronics, Inc., Burbank, Calif.	45
Mead Johnson Laboratories, Evansville, Ind.	20
Merck Sharp and Dohme, Philadelphia, Pa.	8
Merrill Lynch, Pierce, Fenner and Smith, Inc., Jackson, Miss.	25
Meyer Laboratories, Inc., Bloomfield Hills, Mich.	22
Mississippi Hospital and Medical Service, Jackson, Miss.	39

Mutual Benefit Life Insurance Co., Newark, N. J. 19
Ortho Pharmaceutical Corporation, Raritan, N. J. 10
Parke, Davis and Company, Detroit, Mich. 1
Pepsi-Cola Bottling Association, Meridian, Miss. 38
Pfizer Laboratories, New York, N. Y. 16
William P. Poythress and Co., Richmond, Va. 2
A. H. Robins Company, Richmond, Va. 34
William H. Rorer, Inc., Fort Washington, Pa. 18
Sandoz Pharmaceuticals, Hanover, N. J. 35
St. Paul Fire and Marine Insurance Co., St. Paul, Minn. 24
W. B. Saunders Company, Philadelphia, Pa. 32
Schering Corporation, Union, N. J. 6
G. D. Searle and Company, Chicago, Ill. 48
Smith, Miller and Patch, Inc., New York, N. Y. 9
Syntex Laboratories, Palo Alto, Calif. 49
Travelers Insurance Co., Jackson, Miss. 36
Winthrop Laboratories, New York, N. Y. 31

SCIENTIFIC GRANTS

Eli Lilly and Company, Indianapolis, Ind.

Geigy Pharmaceuticals, Ardsley, N. Y.

S. E. Massengill Company, Bristol, Tenn.

Smith, Kline and French Laboratories, Philadelphia, Pa.

REGISTRATION FOR EXHIBIT PRIZES

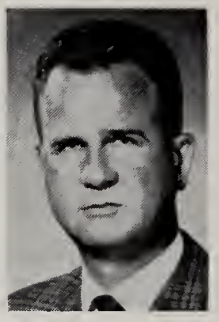
Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Deposit cards at Registration not later that 12:30 p.m., Thursday, May 15.

SCIENTIFIC PROGRAM

Tuesday, May 13, 1969
Hurricane Room E
Beginning at 9:00 a.m.

O. B. Wooley, Jr., Jackson
Chairman

J. Purves McLaurin, Jr., Oxford
Secretary



DR. WOOLEY

PREVENTION OF MATERNAL RH SENSITIZATION—ANTI RH IMMUNE GLOBULIN
William B. Wilson, Jackson

PRACTICAL USE OF STEROIDS AND GONADOTROPHINS IN OB-GYN
Veasy C. Buttram, Jr., Houston, Texas

THERAPEUTIC CONSIDERATIONS IN ENDOMETRIAL CANCER
Richard C. Boronow, Jackson

INDUCTION OF OVULATION
C. D. Christian, Durham, North Carolina

GENETIC COUNSELING
John F. Jackson, Jackson

SCIENTIFIC PROGRAM

Tuesday, May 13, 1969
Hurricane Room E
Beginning at 2:00 p.m.

Dawson B. Conerly, Jr., Hattiesburg
Chairman

M. Beckett Howorth, Jr., Oxford
Secretary



DR. CONERLY

SURGICAL TREATMENT OF ACQUIRED VALVULAR HEART DISEASE
John W. Kirklin, Birmingham, Alabama

RECENT CONCEPTS IN THE DUMPING SYNDROME
Theodore Drapanas, New Orleans, Louisiana

CLOSED ANTIBACTERIAL PERFUSION AND ORTHOPAEDIC INFECTION
Frazier Ward, Jackson

GRANULOMATOUS COLITIS
William O. Barnett, Jackson

SCIENTIFIC PROGRAM

Wednesday, May 14, 1969
Hurricane Room E
Beginning at 9:30 a.m.

John R. Shell, Vicksburg
Chairman

C. Ralph Daniel, Jr., Jackson
Secretary



Dr. Shell

The Value of Low Molecular Dextran in Myocardial Infarction
Per H. Langsjoen, Temple, Texas

Radiologic Aspects of the Congenital Bicuspid Aortic Valve
Larry P. Elliott, Gainesville, Florida

Subaortic Stenosis
Karl Hatten, Vicksburg

Modern Concepts in Treatment of Respiratory Insufficiency
G. Bernard Shaw, Jackson

Curable Hypertension
Herbert G. Langford, Jackson

SCIENTIFIC PROGRAM

Wednesday, May 14, 1969
Hurricane Room E
Beginning at 1:30 p.m.

Steven L. Moore, Jackson
Chairman

Frank J. Morgan, Jr., Jackson
Secretary



Dr. Moore

Acute Illness Among Returnees from Viet Nam
Robert E. Blount, Jackson

Maternal Deaths Due to Hemorrhage in Mississippi—A Ten Year Study
E. J. Price, Jr., Jackson

Pacemaker Management of Heart Block
John W. Bowlin, Tupelo

SCIENTIFIC PROGRAM

Wednesday, May 14, 1969
Hurricane Room E
Beginning at 3:00 p.m.

Hardy B. Woodbridge, Jr., Jackson
Chairman

W. Johnson Witt, Jackson
Secretary



DR. WOODBRIDGE

THORACIC DUCT LYMPH IN THE DIAGNOSIS OF LIVER DISEASE
William R. Cole, St. Louis, Missouri

EXPERIENCES WITH AN OUT-PATIENT ELECTROCARDIOVERSION CLINIC
John H. Woodbridge, St. Louis, Missouri

CLIP GRAFTS FOR INTRACRANIAL ANEURYSMS
Thoralf M. Sundt, Jr., Memphis, Tennessee

SCIENTIFIC PROGRAM

Thursday, May 15, 1969
Gold Room South
Beginning at 9:30 a.m.

John C. Suares, Greenville
Chairman

James K. Williams, Jr., Pascagoula
Secretary



DR. SUARES

ELECTIVE RHINOPLASTY
Lewis J. Rutledge, New Orleans, Louisiana

MANAGEMENT OF INTRAOCULAR FOREIGN BODIES
Morton F. Goldberg, Arlington, Virginia

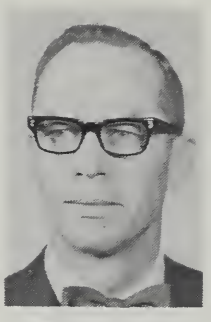
GLAUCOMA THERAPY SIMPLIFIED
Merrill M. Knopf, Jackson

SCIENTIFIC PROGRAM

Thursday, May 15, 1969
Hurricane Room E
Beginning at 10:00 a.m.

Wallace S. Sekul, Biloxi
Chairman

William F. Sistrunk, Jackson
Secretary



DR. SEKUL

SALICYLATE POISONING
J. M. Montalvo, Jackson

NEW APPROACHES TO THE PROBLEM OF RECURRENT INFECTION IN CHILDHOOD
Rebecca H. Buckley, Durham, North Carolina

PEDIATRICS 1969: RECENT ADVANCES AND FUTURE TRENDS
Blair Batson, Jackson

OLE MISS MEDICAL ALUMNI

University of Mississippi Medical Alumni will meet on Monday, May 12. Arrangements for registration at the Buena Vista Hotel have been made by alumni officials. A general business meeting will be conducted at 4:00 p.m. in the Poolside Room. The fellowship hour, buffet supper, and dance will be conducted at the Buena Vista Motel pool area beginning at 7:00 p.m., Dr. Wendell B. Holmes, president, presiding. Other officers are Dr. Hector S. Howard, Memphis, president-elect, and Mr. Charles W. Price, Jackson, secretary. Further details and tickets may be secured from Mr. Price at the University Medical Center, Jackson, or at Ole Miss Registration, the Buena Vista Hotel.

BOURBON STREET PARTY

Sharkey Bonano and his famous New Orleans' Dixieland Band will give the beat for MSMA's fabulous Bourbon Street Party beginning at 6:30 p.m., in the Gold Rooms and Fountain Terrace, the Buena Vista Hotel, on Wednesday evening May 14. Tickets will be available at General Registration in the Hurricane Room Foyer.

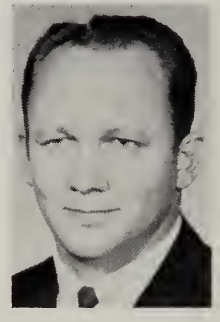
VISITING ESSAYISTS



DR. BUCKLEY

REBECCA H. BUCKLEY, M.D., Durham, North Carolina. Assistant Professor of Pediatrics, Duke University. Medical Education: University of North Carolina, 1958. Diplomate, American Board of Pediatrics.

VEASY C. BUTTRAM, JR., M.D., Houston, Texas. Assistant Professor of Ob-Gyn, Baylor University. Medical Education: University of Texas, 1960. Diplomate, American Board of Ob-Gyn.



DR. BUTTRAM



DR. CHRISTIAN

C. D. CHRISTIAN, M.D., Durham, North Carolina. Associate Professor of Ob-Gyn, Duke University. Medical Education: Duke University, 1958. Diplomate, American Board of Ob-Gyn.

WILLIAM R. COLE, M.D., St. Louis, Missouri. Associate Professor of Surgery, Washington University. Medical Education: Washington University, 1952. Diplomate, American Board of Surgery.



DR. COLE

VISITING ESSAYISTS



Dr. Drapanas

Theodore Drapanas, M.D., New Orleans, Louisiana. Professor and Chairman, Department of Surgery, Tulane University. Medical Education: University of Buffalo, 1952. Diplomate, American Board of Surgery.



Dr. Goldberg

Morton F. Goldberg, M.D., Arlington, Virginia. Assistant Clinical Professor of Ophthalmology, Yale University School of Medicine. Medical Education: Harvard Medical School, 1962. Diplomate, American Board of Ophthalmology.



Dr. Kirklin

John W. Kirklin, M.D., Birmingham, Alabama. Professor and Chairman, Department of Surgery, University of Alabama. Medical Education: Harvard University, 1942. Diplomate, American Board of Surgery.



Dr. Langsjoen

Per H. Langsjoen, M.D., Temple, Texas. Medical Education: University of Minnesota, 1951. Diplomate, American Board of Internal Medicine.

VISITING ESSAYISTS



DR. RUTLEDGE

LEWIS J. RUTLEDGE, M.D., New Orleans, Louisiana. Associate Professor, Department of Otolaryngology, Tulane University. Medical Education: Tulane University, 1947. Diplomate, American Board of Otolaryngology.

THORALF M. SUNDT, JR., M.D., Memphis, Tennessee. Assistant Professor of Neurosurgery, University of Tennessee, 1959. Diplomate, American Board of Neurological Surgery.



DR. SUNDT



DR. WOODBRIDGE

JOHN H. WOODBRIDGE, M.D., St. Louis, Missouri. Chief of Medicine, Deaconess Hospital, St. Louis, Missouri. Medical Education: Tulane University, 1940. Diplomate, American Board of Internal Medicine.

WOMAN'S AUXILIARY TO THE MISSISSIPPI STATE MEDICAL ASSOCIATION

46th Annual Session
Buena Vista Hotel
May 12-14, 1969



MRS. BRUMBY

OFFICERS

MRS. PAUL B. BRUMBY
Lexington
President

MRS. LOUIS C. LEHMANN
Natchez
President-Elect



MRS. LEHMANN

ANNUAL SESSION CHAIRMEN

MRS. J. HURD GADDY
Long Beach
General Chairman

MRS. M. A. TAQUINO
Ocean Springs
Registration

MRS. RAYMOND F. GRENFELL
Jackson
Co-Chairman

MRS. T. E. ROSS, III
Hattiesburg
Luncheon and Publicity

MRS. H. H. ROBINSON
Pascagoula
River Cruise

AUXILIARY

Monday, May 12, 1969

12:00 noon Preconvention Executive Board Brunch
Poolside Room, The Buena Vista

1:00-5:00 p.m. Registration, Mrs. M. A. Taquino, Chairman
Lobby, The Buena Vista

2:00 p.m. Finance Committee Meeting, Mrs. A. T. Tatum

AUXILIARY

Tuesday, May 13, 1969

8:00 a.m. Past Presidents' Breakfast
Mrs. D. L. Clippinger, Presiding
Poolside Room, The Buena Vista

8:00-3:00 p.m. Registration
Lobby, The Buena Vista

12:00 noon Luncheon, The Fountain Terrace
Mrs. T. E. Ross, III, Chairman
Mrs. Paul B. Brumby, Presiding

THEME: "Opening New Doors For Doctors' Wives"
Invocation
Introduction of Guests
Guest Speaker
Mrs. John M. Chenault, Decatur, Alabama
President-Elect, Woman's Auxiliary to the American Medical Association

2:30 p.m. Singing River Cruise
Mrs. H. H. Robinson, Chairman
(Meet in Lobby for transportation, dress casual)

Wednesday, May 14, 1969

8:00-12:00 noon Registration
Lobby, The Buena Vista

8:00 a.m. Continental Breakfast for Auxiliary Members
Gold Room South, The Buena Vista

9:00 a.m. General Session
Mrs. Paul B. Brumby, Presiding
Invocation
Auxiliary Pledge
Mrs. John G. Egger

Welcome
Mrs. James T. Thompson, Moss Point
Response
Mrs. John B. Howell, Jr., Canton
Introductions
Greetings from Joseph B. Rogers, M.D.
President, MSMA
Greetings from James L. Royals, M.D.
President-Elect, MSMA
Credentials and Registration
Mrs. Maurice A. Taquino
Roll Call
Minutes
President's Report
Mrs. Paul B. Brumby, Lexington
Treasurer's Report
Mrs. David D. Wilson
AMA-ERF Report
Mrs. A. E. Brown
Finance Report
Mrs. A. T. Tatum
Appointment of Delegates to AMA Woman's Auxiliary Meeting
Unfinished Business
New Business
Memorial Service
Mrs. Howard A. Nelson

1:30 p.m. Report of Nominating Committee
Mrs. D. L. Clippinger, Hazelhurst
Election of General Officers
Installation of General Officers
Courtesy Resolutions
Mrs. T. A. Baines
Adjournment

2:30 p.m. Postconvention Executive Board Meeting
Gold Room South, The Buena Vista

6:30 p.m. MSMA "Bourbon Street" Party
Fountain Terrace and Gold Rooms
The Buena Vista

MISSISSIPPI ORTHOPAEDIC SOCIETY

Buena Vista Hotel
May 12, 1969

PAUL S. DERIAN, Jackson, President
WILLIAM B. THOMPSON, Jackson, President-Elect
LOUIS A. FARBER, Jackson, Secretary

12:00 noon Luncheon, Sun Room

1:00 p.m. Scientific Meeting
Paul S. Derian, Moderator
OS CALCIS FRACTURES
William C. Warner, Jackson
Discussor: William F. Owens, Jackson
DOUBLE CONTRAST STUDIES OF THE KNEE
John E. Evans, Vicksburg
Discussor: James C. Manning, Jackson
THE FIBULA-A CLINICAL DISCUSSION
Robert A. Murray, Temple, Texas
Guest Lecturer
CLOSED IRRIGATION IN SEPTIC ORTHOPEDIC CONDITIONS
E. Frazier Ward, Jackson
Discussor: Donald T. Imrie, Vicksburg

3:00 p.m. Business Meeting

MISSISSIPPI COMMISSION ON HOSPITAL CARE

The Mississippi Commission on Hospital Care will meet on Monday, May 12, in the Gold Room South, the Buena Vista Hotel, at 9:00 a.m. Additional information will be supplied by Mr. Foster L. Fowler of Jackson, executive director of the commission.

TENNIS TOURNAMENT

A men's double championship tennis tournament will be conducted at Keesler AFB on the afternoon of Monday, May 12, and morning of Tuesday, May 13. Awards to winners will be at General Registration Tuesday afternoon. Advance registration is encouraged, sending name and $3.00 fee to Dr. W. Johnson Witt, 515 Medical Arts Building, Jackson 39201.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

Buena Vista Hotel
May 13, 1969

M. Beckett Howorth, Jr., M.D., Oxford, President
Richard F. Riley, M.D., Meridian, President-Elect
Dawson B. Conerly, Jr., M.D., Hattiesburg, Secretary

9:00 a.m. Scientific Meeting, Sun Room
M. Beckett Howorth, Oxford, Presiding
The Future of Liver Transplantation
Theodore Drapanas, New Orleans, La.
The Application of Some Lessons from Open Heart Surgery to General Surgical Problems
John W. Kirklin, Birmingham, Ala.
Problem Cases in Surgery
Case Presentations (Five Minutes)
General Discussion (Five Minutes)
Pulmonary Emboli
J. P. Culpepper, III, Hattiesburg
Diuretic Ulcerations of Intestine
Richard H. Johnson, Jackson
Cardiac Pacemaker
Henry B. Tyler, Jackson
Femoro-popliteal Bypass
W. Briggs Hopson, Jr., Vicksburg

11:45 a.m. Business Meeting

12:30 p.m. Luncheon, Gold Room South

2:00 p.m. General Scientific Session, Hurricane Room E

GOLF TOURNAMENT

The annual association golf tournament will be conducted at the Sunkist Country Club on Wednesday, May 14, Dr. A. V. Hays of Gulfport, chairman. The $10 entrance fee includes one green fee ticket and two 19th Hole refreshment tickets. Awards to winners will be made at 5:00 p.m. in the clubhouse. Handicaps are not needed, the two flights being divided among those over and under 55 years of age. Advance registration is encouraged, sending name and fee to Dr. Hays at the ENT Hospital, 13th and 31st Avenue, Gulfport 39501. Tuesday rounds are acceptable for the single round 18 hole play. Preregistrants may pick up tickets at the pro shop; others at General Registration at the Buena Vista Hotel. Club facilities are available to players' families.

LOUISIANA-MISSISSIPPI OPHTHALMOLOGICAL AND OTOLARYNGOLOGICAL SOCIETY

The Edgewater Gulf
May 15-17, 1969

HUGH H. JOHNSTON, Vicksburg, President
MILES L. LEWIS, JR., New Orleans, President-Elect
ARTHUR V. HAYS, Gulfport, Secretary-Treasurer

Thursday, May 15, 1969

5:00-7:00 p.m. Registration and Cocktails, Convention Hall

Friday, May 16, 1969

8:00 a.m. Registration, Convention Hall

9:00 a.m. Meeting called to order, Convention Hall
Introduction of New Fellows and Candidates Announcements.

9:15 a.m. President's Address
Hugh H. Johnson, Vicksburg

9:35 a.m. BENIGN LESIONS OF THE LARYNX
Charles M. Norris, Philadelphia

11:00 a.m. CONCEPTS USEFUL IN EVERYDAY RHINOLOGICAL SURGERY
Francis L. Weille, Boston
Immediately following adjournment at about 12:15 p.m., there will be a meeting of the Louisiana Eye, Ear, Nose, and Throat Society.

12:30 p.m. Luncheon: Ophthalmology, with Speakers, Crystal Ballroom
Otolaryngology, with Speakers, West End Marine Dining Room

2:15 p.m. SURGERY OF THE ORBIT
Gilbert W. Cleasby, San Francisco

3:30 p.m. THE OPHTHALMOLOGIST AND CAROTID OCCLUSIVE DISEASE
Thomas P. Kearns, Rochester

4:15 p.m. Council Meeting, Parlor E

Saturday, May 17, 1969

8:30 a.m. Registration, Convention Hall

9:00 a.m. Executive Session for Fellows, Convention Hall
Coffee Break

10:30 a.m. Unusual Neurological Motor Anomalies of the Eye
Thomas P. Kearns, Rochester

11:45 a.m. Photocoagulation of Retinal Disease
Gilbert W. Cleasby, San Francisco

2:30 p.m. Problems of the Busy Specialist
Francis L. Weille, Boston

3:45 p.m. Foreign Bodies in the Air and Food Passages
Charles M. Norris, Philadelphia

ENTERTAINMENT FEATURES

Friday, May 16, 1969

9:00-10:00 a.m. Ladies Coffee Hour, Hawaiian Terrace

7:30 p.m. Seafood Jamboree, Poolside. Dixieland music, dress casual.

Saturday, May 17, 1969

7:30 p.m. Cocktails

8:00 p.m. Dinner Dance, Music by Rene Louapre

GOLF AND TENNIS TOURNAMENTS

Golf tournament will be held during the meeting and is limited to Fellows, physician-guests, and their ladies, registered at the meeting. Those desiring to participate are requested to notify Dr. C. Hal Cleveland, Eye, Ear, Nose and Throat Hospital, Gulfport, Mississippi, prior to the meeting and must register (at Registration Desk) not later than 12:00 noon, Friday, May 16.

Tennis tournament will be held if the proper facilities are available. If so, those desiring to participate contact Dr. Robert A. Little, Eye, Ear, Nose and Throat Hospital, Gulfport, Mississippi, for further details.

REGISTRATION FEES

For Fellows of the Society and residents in ophthalmology and and otolaryngology, there are no fees, but residents must have certificates from their superintendent or chief. For ophthalmologists and otolaryngologists in service, $5.00, and for all others, $15.00. This fee covers all charges except for luncheon, $2.50; for guests at the dinner and dance, $10.00; and registration fees for golf and tennis tournaments.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

Members of the Mississippi Association of Pathologists will meet on Sunday and Monday, May 11-12. The association will begin activities with a business session at 1:00 p.m., Sunday, May 11, in the Poolside Room, the Buena Vista Motel. A Seminar on Pediatric Pathology, open to all physicians, will be conducted on Monday, May 12, beginning at 9:00 a.m. in the Card Room, the Buena Vista Hotel, featuring Drs. Marie A. Valdez-Dapena and James B. Arey of Philadelphia, Pennsylvania. Officers are Drs. Kenneth C. Coffelt, Biloxi, president; George M. Sturges, Jackson, president-elect; and William V. Hare, Jackson, secretary-treasurer.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will conduct a business meeting on Monday, May 12, beginning at 1:30 p.m. in the Card Room, the Buena Vista Hotel. Officers are Drs. Joel L. Alvis, Jackson, president; and Charles D. Scruggs, Jackson, secretary.

AMERICAN COLLEGE OF OB-GYN

Mississippi Fellows of the College will meet on Tuesday, May 13, for a breakfast beginning at 7:30 a.m. in the Card Room, the Buena Vista Hotel. Dr. Dan R. Thornton, Jr., of Meridian is in charge of arrangements.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Tuesday, May 13, beginning at 11:30 a.m. in the Poolside Room, the Buena Vista Motel. Officers are Drs. J. Purves McLaurin, Jr., Oxford, president; William S. Cook, Jackson, president-elect; and Charles M. Head, Jackson, secretary.

FIFTY YEAR CLUB

Members of the Mississippi State Medical Association's Fifty Year Club will be honored at a luncheon on Tuesday, May 13, in the Card Room the Buena Vista Hotel. Dr. C. D. Taylor of Pass Christian, Chairman of the Board of Trustees, will preside.

FLYING PHYSICIANS ASSOCIATION

Mississippi members of the Flying Physicians Association and nonmember physicians interested in private aviation will meet for a luncheon on Monday, May 12, in the Fiesta Room, the Buena Vista Hotel, at 12 o'clock noon. Officers are Drs. Charles H. Heywood, Canton, president; and John J. White, Jackson, secretary.

VANDERBILT MEDICAL ALUMNI

Vanderbilt Medical Alumni will meet on Tuesday, May 13 in the Poolside Room, the Buena Vista Motel for a reunion and fellowship hour beginning at 5:30 p.m. Dr. John L. Shapiro of Vanderbilt University will be the honored guest. Arrangements are being handled by Dr. Archibald C. Hewes of Gulfport.

TULANE MEDICAL ALUMNI

Medical Alumni of Tulane University will sponsor a fellowship hour on Tuesday, May 13, in the Sun Room, the Buena Vista Hotel, beginning at 5:30 p.m. Dr. Robert A. Little of Mississippi City is program chairman.

TENNESSEE MEDICAL ALUMNI

Medical graduates of the University of Tennessee will meet on Tuesday evening, May 13, for a fellowship hour and dinner beginning at 6:30 p.m. in the Fountain Terrace Room, the Buena Vista Hotel. Dr. G. Swink Hicks of Natchez is arrangements chairman.

MISSISSIPPI RADIOLOGICAL SOCIETY

The Mississippi Radiological Society will conduct a dinner and scientific meeting on Tuesday evening, May 13, beginning at 6:30 p.m. in the Gold Room South, the Buena Vista Hotel. Dr. Larry P. Elliott of Gainesville, Florida, will be the scientific speaker. Officers are Drs. Robert D. Sloan, Jackson, president; and Otis G. Ball, Jackson, secretary.

MSMA PAST PRESIDENTS' BREAKFAST

Past Presidents of the Mississippi State Medical Association will enjoy a breakfast meeting on Wednesday morning, May 14, at 7:30 a.m. in the Poolside Room, the Buena Vista Motel. Dr. Temple Ainsworth of Jackson will preside .

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will conduct a luncheon on Wednesday, May 14, beginning at 12:00 noon in the Sun Room, the Buena Vista Hotel. Officers are Drs. Joe S. Covington, Meridian, president; and S. H. McDonnieal, Jackson, secretary.

MISSISSIPPI PSYCHIATRIC ASSOCIATION

Members of the Mississippi Psychiatric Association will meet on Wednesday, May 14, for a luncheon beginning at 12:00 noon in the Poolside Room, the Buena Vista Hotel. Dr. Max Sugar of New Orleans will be the featured scientific speaker. Officers are Drs. James F. Suess, Jackson, president; George C. Hamilton, Jr., Jackson, president-elect; and William C. Quinn, Jackson, secretary.

MAGP LUNCHEON

The Mississippi Academy of General Practice will sponsor a luncheon on Wednesday, May 14, in the Fountain Terrace Room, the Buena Vista Hotel, beginning at 12:00 noon. Officers are Drs. Charles R. Jenkins, Laurel, president; Walter W. Crawford, Tylertown, president-elect; William H. Parker, Heidelberg secretary; and Miss Louise Lacey, Jackson, executive secretary.

DIABETES ASSOCIATION OF MISSISSIPPI

All interested physicians are invited to attend the meeting of the Diabetes Association of Mississippi which will be conducted on Wednesday, May 14, in the Sun Room, the Buena Vista Hotel, beginning at 4:00 p.m. Officers are Drs. W. J. Huddleston, Hattiesburg, president; John D. Wofford, Greenwood, president-elect; and Alton B. Cobb, Jackson, secretary.

MISSISSIPPI EENT ASSOCIATION

Members of the Mississippi Eye, Ear, Nose, and Throat Association will conduct a business meeting and luncheon on Thursday, May 15, beginning at 12:00 noon in the Sun Room the Buena Vista Hotel. Officers are Drs. John J. White, Jackson, president; Samuel B. Johnson, Jackson, president-elect; and L. Benjamin McCarty, Jackson, secretary.

Handbook of the House of Delegates

Mississippi State Medical Association
101st Annual Session, Biloxi
May 12-15, 1969

REPORT OF THE NOMINATING COMMITTEE

Procedural Change. At the 100th Annual Session in 1968, Section 2, Chapter VI, By-Laws of the association, was amended to make the Nominating Committee a continuing, constitutional body of the House of Delegates, selected in district caucuses one year in advance of the annual session to which nominees are reported.

It is now the duty of the committee "to consult with members of the association through their respective component medical societies; to consult prospective nominees for office as to their willingness and ability to serve, if elected; to conduct a formal meeting at least three months prior to the annual session at which elections are to be held and to agree upon a slate of nominees at this meeting; and to publish to the membership this slate of nominees not later than one month prior to the next annual session."

Your committee found it necessary to meet on two occasions, Jan. 23 and Feb. 20, 1969. We encountered great difficulties related to eligibility provisions imposed by the Constitution, and many of our nominees must be registered and in attendance at the 101st Annual Session to remain on the ballot. Your committee has reported in detail to the Board of Trustees, soliciting the support of the Board in resolving this and other problems related to the new procedure.

The list of offices to be filled by election at the 101st Annual Session was prepared and disseminated in Aug. 1968. It has been published in the JOURNAL together with news stories about the new procedure. The list was furnished to the Board of Trustees Aug. 28, 1968.

Following are nominations for consideration by the House of Delegates. The attention of the House is invited to Section 3, Article VI, of the Constitution which states in part that "no person shall be elected to any such office who has failed to attend two-thirds of the past two and current annual sessions and who has not been a member for the past two years." An asterisk (*) before the name of a nominee indicates that he has attended only one of the past two annual sessions and must be present at the 101st Annual Session to be eligible for election to office.

President-elect (vote for one)

A. V. Beacham, Magnolia
G. Lacey Biles, Sumner
Paul B. Brumby, Lexington

HANDBOOK INFORMATION

The Speaker and Vice Speaker of the House of Delegates herewith present for the information of all members those reports and resolutions as have been received for publication in advance of the 101st Annual Session. It is the intent of this advance publication to inform the membership and to afford all concerned the opportunity to confer with delegates over any aspect of the reports and resolutions.

No report or resolution herein becomes official or a statement of policy until formally presented to the House of Delegates and acted upon at the annual session.

WILLIAM E. LOTTERHOS
SPEAKER

JOHN B. HOWELL, JR.
VICE SPEAKER

HOUSE OF DELEGATES / Continued

Vice Presidents

For Northern Area (Districts 1, 2, and 3) (vote for one)

G. Leroy Howell, Starkville
James L. Thornton, New Albany
Eugene E. Tibbs, Cleveland

For Mid-State Area (Districts 4, 5, and 6) (vote for one)

*William B. Hopson, Jr., Vicksburg
*Jay J. Kazar, Tchula
J. Dan Mitchell, Jackson

For Southern Area (Districts 7, 8, and 9) (vote for one)

Jack A. Atkinson, Brookhaven
*Arthur V. Hays, Gulfport
*Albert G. Tillman, Gulfport

Editor, 1969-1972 (vote for one)

G. Spencer Barnes, Columbus
*W. Moncure Dabney, Crystal Springs
*John R. Shell, Vicksburg

Associate Editor, 1969-1971 (vote for one)

Seiberth S. Kety, Picayune
Thomas W. Wesson, Tupelo

Delegate to AMA, Jan. 1, 1970-Dec. 31, 1971 (vote for one)

G. Swink Hicks, Natchez
C. R. Jenkins, Laurel

Alternate Delegate to AMA, Jan. 1, 1970-Dec. 31, 1971 (vote for one)

Joseph B. Rogers, Oxford
James L. Royals, Jackson

Board of Trustees, 1969-1972 (vote for one for each district)

District 7

William E. Moak, Richton
*William E. Weems, Laurel

District 8

Jack A. Atkinson, Brookhaven
Everett Crawford, Tylertown

District 9

Bedford F. Floyd, Jr., Gulfport
James T. Thompson, Moss Point

Council on Budget and Finance, 1969-1972 (vote for one)

Julian T. Janes, Jr., McComb
George D. Purvis, Jackson

Council on Constitution and By-Laws, 1969-1972 (vote for one)

*Tom H. Mitchell, Vicksburg
Lawrence Boling Morris, Macon

Council on Medical Education, 1969-1972 (vote for one)

Karl B. Horn, Pascagoula
Dennis E. Ward, Corinth

Council on Legislation, 1969-1972 (vote for one for each district)

District 7

A. T. Tatum, Petal
*James C. Waites, Laurel

District 8

A. V. Beacham, Magnolia
David L. Clippinger, Hazlehurst

District 9

Eldon L. Bolton, Biloxi
C. D. Taylor, Jr., Pass Christian

Judicial Council, 1969-1972 (vote for one for each district)

District 4

Paul B. Brumby, Lexington
*James E. Booth, Eupora

District 5

Martin E. Hinman, Vicksburg
William B. Wiener, Jackson

District 6

Charles M. Moore, Philadelphia
*Reginald P. White, Meridian

Council on Medical Service, 1969-1972 (vote for one for each district)

District 1

*Van R. Burnham, Clarksdale
*John F. Lucas, Jr., Greenwood

District 2

*Eddie E. Bramlitt, New Albany
James O. Gilmore, Oxford

District 3

*John C. Longest, Starkville
Jack A. Stokes, Pontotoc

State Board of Health, PH District 2, 1970-1975 (vote for three)

G. Lacey Biles, Sumner
*Julian C. Bramlett, Oxford
*Thomas L. Ketchum, Ripley
*John R. Lovelace, Batesville
Herbert S. Phillips, Holly Springs
James L. Thornton, New Albany

State Board of Health, PH District 4, 1970-1975 (vote for three)

S. Lamar Bailey, Kosciusko
Thomas N. Braddock, Jr., West Point
Samuel B. Caruthers, Grenada
Edward Pennington, Ackerman
Joseph H. Shoemaker, Okolona
Lester D. Webb, Calhoun City

State Board of Health, PH District 5, 1970-1975 (vote for three)

Lamar Arrington, Meridian
*William R. Eure, Bay Springs
*Walter D. Gunn, Quitman
*Prentiss F. Keyes, DeKalb
*John R. Laird, Union
*George G. Townsend, Forest

REPORT OF THE DELEGATES TO AMA

Reporting Format. Your Delegates to the American Medical Association continue to limit their report to this House of Delegates to policy actions at AMA level because of the continued excellent reporting in the *AMA News* and *Journal AMA* of scientific and subsidiary activities of the annual and clinical conventions. This report is concerned with the San Francisco and Miami Beach conventions conducted in 1968. There were no special or called meetings of the House of Delegates during the year.

Dr. G. Swink Hicks of Natchez was seated for the first time at the San Francisco annual convention. Both of your regularly elected Delegates, Dr. Hicks and the incumbent senior Delegate, Dr. Howard A. Nelson of Greenwood, attended and participated in each convention. We are grateful that our President, President-elect, a Trustee, and many members have been in attendance upon these conventions. We note also with pride participation by a number of Mississippi physicians in the Scientific Assembly and the fact that Dr. William E. Lotterhos of Jackson serves as a member of that AMA council.

San Francisco Annual Convention. The 117th Annual Convention was conducted June 16-20, and the House of Delegates was in session four days considering 143 items of business, including 84 resolutions, 39 reports of the Board of Trustees, and the remainder from councils.

Major issues before the House included elimination of discrimination in membership, health care costs and financing, governmental relations, health manpower, medical education, infant mortality, transplantation of human tissue, and the financial status of AMA.

A strong and punitive resolution sponsored by the Massachusetts delegation called for amendment of the By-Laws to provide avenues of appeal for physicians "who allege that they, because of color, creed, race, religion, or ethnic origin, have been unfairly denied membership in a component and/or constituent association." The resolution provides that the Judicial Council, upon determining that the allegations are indeed true, may admonish or censure the component or constituent (state) association. In case of repeated violations, the Council may recommend to the House of Delegates that the state association involved be declared to be no longer a constituent association of the AMA.

An array of related actions were concerned with care costs and financing. Support of voluntary prepayment and health insurance was reaffirmed, and the concept of tax credits for medical care expenditures, including premiums for insurance, was recommended. The House called for placing care costs in true perspectives and for maximum effective utilization of health manpower and facilities.

Comprehensive health planning participation by physicians and societies was encouraged, and the House warned against accrual of such activities and prerogatives to state and federal agencies of government. A new Council on Health Manpower was created as a council of the Board of Trustees, and it was reported that negotiations between medicine and osteopathy have been rendered difficult "in the absence of cooperative leadership."

State associations were urged to continue and intensify support of medical education and medical schools, and essentials of approved residencies in general practice, physical medicine and rehabilitation, psychiatry, and anesthesiology were revised.

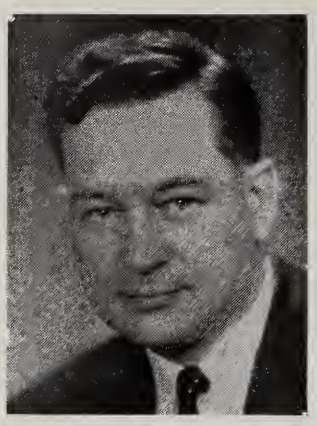
A new policy statement on infant mortality urges medical concern over environmental conditions, health education, and broad and inclusive care of unwed mothers. A report of the Judicial Council stating that "when a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician . . ." was approved.

The House was informed that "fiscal uncertainties" lie ahead for AMA, and the report of the Board of Trustees stated that "a substantial increase in the budget of the AMA will be necessary within the next few years. . . ." Additionally, AMA will, beginning with the tax year 1968, pay taxes on approximately $13 million advertising income. A number of organization changes related to terms of office and structure of the Scientific Assembly were approved.

An unpleasant interruption in the House of Delegates by representatives of the Medical Committee on Human Rights occurred at the opening session of the House of Delegates.

Miami Beach Clinical Convention. The major action at the Dec. 1-4 clinical convention was amendment of the By-Laws providing appeal avenues for those applicants for membership alleging

(Turn to page 182)



The President Speaking

'Must We Be Last?'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

MISSISSIPPIANS GROW WEARY of continually appearing as the last digit in the statistical series. This familiar phenomenon seems to turn up in everything from per capita income to the total miles of interstate highways. When our state excels, as it does, in so many areas of endeavor and achievement, the "Mississippi's last" cliché is an accent on the negative.

It is true that we are short in medical manpower, but so is the rest of the United States. And even the degree of scarcity is debatable, because location, utilization, capabilities, and a host of variables enter into the picture to shade such a judgment. We have done particularly well in hospital construction, because on a state-by-state basis, existing general medical and surgical beds average 409 per 100,000 population. The low is Alaska with 238 beds, and the high is North Dakota with 556 beds. Mississippi stands near the top with 414 beds, above the national mean.

Among our physician population, we have a healthy balance of those in family practice, and the new specialty board will help build medicine's front line in patient care. Distribution of specialists in our state is far above the mere acceptable minimum, and we are fortunate to have growing centers where virtually all specialty services are available.

For many years, professional fees have been depressed in the deep South, and this picture is changing, too. True, the change is slow with the upward trend lagging in comparison with our sister states. But insurance and prepayment plans are showing signs of recognizing this inequity as more programs move toward professional compensation under the concept of usual and customary fee. Our association has made and will continue to make positive contributions in maintaining service potential, updated knowledge and skills through postgraduate education, and costs control through fee and utilization review. We are moving up in the statistical series. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME X, NUMBER 4

April 1969

EDITORIALS

Group Practice: Pattern of the Future?

I

In the practice of medicine, two is a partnership, but three is a group. At least that's the AMA definition which says that "group medical practice is the application of medical service by three or more physicians formally organized to provide medical care, consultation, diagnosis, and/or treatment, through the joint use of equipment and personnel and with income from medical practice distributed in accordance with methods previously determined by members of the group."

The growth of group practice in the past two decades has been something of an unreported phenomenon on the American medical scene. In all probability, this innovation has exercised far more impact upon the private care delivery system than has been generally recognized or appreciated. In fact, group practice in the United States has increased by a whopping 275 per cent in the last 10 years with a 200 per cent increase in the number of physicians participating.

In 1946, the U. S. Public Health Service made a survey of American medicine and discovered only 404 identifiable medical groups. But a second USPHS study in 1959 identified 1,546 groups with a combined membership of about 13,000 physicians. A survey in 1965 by AMA turned up 4,289 groups with some 28,000 members. And there is a phenomenon within this phenomenon: In 1946, only 8.9 per cent of all groups were single specialty; by 1965, 50.4 per cent were single specialty. Yet, the total of physicians in multispecialty groups substantially outnumbers—by some 60.4 per cent—those in single specialty organizations.

There are pros and cons, but group practice is a clear and pronounced trend. It may be the pattern of the future.

II

The origin of group practice is obscure, and we may accurately note, albeit with tongue in cheek, that it didn't begin until sometime after 361 B.C., because Hippocrates was a solo practitioner. Some medical historians believe that groups began as expanding family practice units, and the Mayo Clinic, for example, was founded in the late 1890's. But the famous name was not adopted until 1914.

We do know that compelling reasons were apparent for organization of physicians into groups. Large practices developed, requiring associates, and advances in surgery made the team a necessity. Physicians working together in World War I seemed to like the idea of a group, and it was obviously desirable to pool resources in acquisition of expensive equipment and use of medical assistants.

Six types of group practice are classically identified, and these are recognized by the Ameri-

can Association of Medical Clinics, the Medical Group Management Association, and AMA. They are:

—*The multispecialty group.* These provide general medical and surgical care and are typically made up of internists, general surgeons, and at least one other major specialty.

—*General practice groups.* The designation tells the story, and the orientation of these groups is family practice. With the advent of the new American Board of Family Practice, medicine may properly anticipate a proliferation and growing importance of these units.

—*Mixed general practice and specialty groups.* Usually, these groups are structured around a nucleus of family practitioners with one or more additional members in a major specialty.

—*Single specialty groups.* This is the phenomenon within the phenomenon and the most frquently encountered form of group. Almost every specialty shows up well in the single discipline category.

—*Diagnostic clinics.* Generally, these groups represent pathology, radiology, and internal medicine and limit professional endeavors to diagnostic work.

—*Medical school and hospital groups.* These are the newest type of groups on the medical horizon. They are usually composed of university faculty members or full time hospital staff physicians who desire to devote a portion of their time to private practice.

In the same context of classifications, groups are ordinarily organized in one of four ways. A majority of the units are partnerships, consisting of senior and junior partners who sometimes employ other physicians who may become partners. They share the profits or losses, distribute income according to a preagreed formula, and the professional acts of a member are usually binding legally upon the others, except in unusual circumstances.

A growing number of groups are professional corporations, formed as such for tax advantages. There is debate over the durability of the many court desisions supporting professional corporations, despite this popular trend. The regulatory powers of the Department of the Treasury have twice staggered these corporations, only to be set aside by the courts. A bill to amend the Internal Revenue Code of 1954 by recognizing in federal tax law the device of the professional corporation, H.R. 173, 91st Congress, is pending. Still others are professional associations, a blending of corporations and partnerships. To be eligible for tax benefits, the association-type group must possess more corporate than partnership characteristics.

The fourth and least encountered form of group organization is sole ownership. This is where a physician is so successful in reputation and practice that he is able to attract his associates solely on an employment basis.

III

The designation "group practice" has acquired a slightly distasteful connotation in recent years, and that's the one relating to prepaid or closed panel plans. Examples are the Kaiser Permanente program, the Health Insurance Plan of New York (HIP), Ross-Loos Clinic of Los Angeles, and the Rip Van Winkle Clinic in New York.

The vast majority of medical groups are compensated on a fee-for-service-basis, meaning that they are paid only when service is rendered. By contrast, the prepaid groups levy an annual subscription on participants whether services are rendered or not, although such groups ordinarily provide services without significant limitation to subscribers. Usually, the patient has no free choice of physician.

There should be no confusion with voluntary prepayment (Blue Shield and Blue Cross) and voluntary health insurance *vis-a-vis* prepaid group practice. The eight Americans out of 10 with voluntary protection can hire and fire their physician at will, and this is generally not so in the prepaid group.

The present purpose is not to engage in a compilation of merits and demerits of group practice characteristics but rather to describe them. Let it be said, however, that denial of free choice of physician is to be condemned, and it cannot contribute to the best medical care.

IV

Group practice offers advantages and disadvantages to patients and physicians alike. The patient, on the one hand, has continual and ready access to medical care in the group, assurance of emergency service when needed, a complete history in one place, and ease of paying for medical care through a central administration. On the other hand, the patient may not always be able to see his favorite group member, or he may feel that the clinic atmosphere is impersonal and factory-like.

For physicians, the group situation assures more regular hours and priceless time for leisure and family. Clinical advantages show up in con-

sultation opportunities, better equipment than the solo practitioner usually possesses, and adequate allied professional assistance. The economic benefits are many with a built-in sense of security, the opportunity to enter practice without heavy investment, and reasonable assurance of stable income.

On the minus side, a group member gives up some measure of independence and individualism, and in multidiscipline groups, referrals may not flow in as they do to solo specialists. Each group member, however competent, must share to some extent in the errors of his associates, and occasionally, a member in the minority must abide a majority policy decision which he dislikes. The group must sustain the member who produces less than others, and any member may be restrained in his expenditures related to the practice.

But American physicians in growing numbers appear to weigh the advantages over the disadvantages as group practice grows. At this stage of mushrooming development, it may not yet be the wave of the future, but it is a pattern which is here to stay.—R.B.K.

Medicine Under Attack: Crazy Contradictions

American medicine is under attack, and the whole crazy picture is a series of contradictions. Almost nobody fails to praise medical science and the forward thrusts in diagnosis and therapy which has been the hallmark of man's achievement in the last two decades. But at every quarter, there are snipers pinging away at the delivery system, costs, and a host of dissatisfactions which, for the most part, have never been brought seriously before medical organization.

To say the very least, the detractors are hardly consistent, and many of the charges are old, musty issues of an era long gone. This has been the classic pattern of the "exposé" books on the profession.

Now comes *Time* Magazine and even the respected *Wall Street Journal,* although the latter largely confined its comment to AMA's internal difficulties at policy and management level. The *Time* blast centered around the costs of care, something which is highly attractive to anybody with an inclination to lay it on the physicians. Most of us have no time, opportunity, or need, for that matter, to attain the Ph.D. in medical socioeconomics, but we can apply ourselves to a more complete understanding of care cost structures, the reasons for cost levels in an inflated economy, and the relationship of medical service costs to the other goods and services which we as a society must have.

And we must understand that the greater portion of care costs are generally beyond the control of the physician. The costs of construction of medical facilities, minimum wage laws, supplies, hospital management decisions, and a host of factors weighing heavily on the price index are *fait accompli* when the doctor of medicine hears about them, just as does the consumer of medical care.

There can be no genuine comfort in one's distress through the discomfort of others, but let it be said that the onslaught on medicine seems to be part of the unhappy state of society which more nearly resembles revolution than accelerated evolution. Whether these tragic events are the disease or a symptom of a disease is rhetorical; they are real, and the nation is the poorer for their having occurred.

The future of American medicine rests in the heart and mind of the individual physician, for it is he—and only he—who cares for the patient, who makes the professional judgment, and who represents his 300,000 American colleagues. Regrettably, there will always be a *Time* Magazine around, although like *Liberty, Collier's, Literary Digest,* and the *Saturday Evening Post,* they will come and go from the American scene. Meanwhile, medicine will endure.—R.B.K.

Ole Miss Grows Pot

Where else but Ole Miss could they grow marijuana—legally and with federal funding?

The School of Pharmacy is conducting about as unique a research project as can be found in the nation today: pot farming. It's all perfectly on the up and up with a $99,000 grant from the National Institutes of Health. And the school, in all good humor, is absorbing the jibes and jokes while it goes seriously about the intriguing and important project.

Dr. Norman J. Doorenbos, chairman of the Department of Pharmacognosy, underscores the need for the research by pointing out that "all we've had is contraband material confiscated by the Bureaus of Customs and Narcotics. This material has an uncertain history as to its age, origin, and variety of plant from which it came."

Dr. Doorenbos also stresses that the true chemical composition of marijuana is not known,

despite its prominence in the pharmacological and medical literature.

The investigators have already found, for example, that the length of day enters into the type of plant produced. Marijuana sown in August is a different plant from one sown in June, they report. The project is less than one year old and is rather hush-hush, too.

There are a number of "pot plots" producing the weed over the state, but all such locations except one are closely guarded secrets. The one identified plot growing marijuana is on the Oxford campus, well guarded by a supposedly-unclimbable 10-foot fence. Moreover, the project is watched over by federal agents, and School of Pharmacy investigators work in the research only after clearance by the Bureau of Narcotics.

In addition to research at Ole Miss, the project will supply mature marijuana plants to three other research institutions (appropriately unnamed) to conduct further studies. The overall project will seek to synthesize marijuana and to analyze properties of the smoke.

Although the Ole Miss project is the only legally produced marijuana in the nation at the moment, it is not the first. During World War II, selected midwestern farmers grew marijuana for fiber value under government supervision, and the U. S. Department of Agriculture is said to have produced modest quantities. But Ole Miss has got to take the cake for unique research. After all, who else is growing pot with federal funding? —R.B.K.

Medical Schools and Tax Support

The basic operating expenses of tax-supported medical schools in the United States have risen about 225 per cent since 1959. In terms of dollars, this was an increase to $429 million from $175 million. Now, as in 1959, the largest single source of support is from state government appropriations, as is proper in the case of a state university or college.

State funds for the tax-supported schools went to $133 million from the 1959 level of just under $50 million, up to 31 per cent of basic operating costs from 28 per cent. Yet, the overall medical school share of state tax funds has decreased. From a national expenditure of $2.9 billion for higher education in government-sponsored schools in 1959 when the medical schools' share was 1.7 per cent, the level of spending is now estimated to be $8.5 billion with medical institutions receiving 1.6 per cent.

Tuition and student fees, stiff as they are in medical schools, account for only 10 per cent of basic operating expenses. Administrative overhead on contracts and grants comes to 14 per cent, second only to state appropriations. Grants, being devoted to research and demonstrations, must be excluded from the schools' basic operating tab.

The Association of American Medical Colleges understates the case by saying that "in reviewing the sources of support (of the state tax-supported schools), the vulnerability of the institutions to fluctuations in overhead regulations becomes apparent."

Although unrestricted gifts and grants account for only 3.3 per cent of the basic expense, these are vital and valuable dollars to the schools. They are alumni and AMA-ERF dollars which come voluntarily without the strings of federal grants. Dr. Robert Q. Marston, former dean and director of the University Medical Center, was fond of saying that "an AMA-ERF dollar is worth two of all the other kinds."

The financial dilemma of American medical schools is a difficult one, and it deserves the understanding of all. Since only a profession can procreate itself, the matter is an appropriate concern to physicians. A vast majority of the schools will welcome both concern and criticism of physicians in attacking these problems, and this is not merely one of pouring in money without end but rather one of working actively to identify critical areas of need, validated and demonstrated, and doing something about them. What really counts is the next generation of American physicians.—R.B.K.

POSTGRADUATE CALENDAR

CIRCUIT COURSES

Physicians in the Natchez and Columbus areas will host their third postgraduate education Circuit Course April 15 and 22 respectively. Topics for the dinner meetings will be peripheral vascular disease, arteriograms and the surgical approach. The Natchez course is at 7:00 p.m. at Jefferson Davis Memorial Hospital and the Columbus group will gather at a new location, the Downtowner Motor Inn, at 6:30 p.m.

East Central Circuit—Session 3

Meridian—May 6
Northwood Country Club, 6:30 p.m.
Eye Ground Manifestations of Systemic Disease, Dr. Samuel Johnson
Thyroid Problems in Infants and Children, Dr. Jose Montalvo

FUTURE CALENDAR

April 1

Circuit Course, Meridian

April 15

Circuit Course, Columbus

April 22

Circuit Course, Columbus

May 6

Circuit Course, Meridian

May 12-15

Mississippi State Medical Association

PERSONALS

Robert L. Abney of Jackson has been appointed a Head Start consultant by the American Academy of Pediatrics. Under the nationwide consultation service, the Academy assists the Office of Economic Opportunity in the Head Start program with professional monitoring of medical programs.

William H. Anderson of Booneville has been awarded a certificate from the President of the United States in recognition of his 20 years of uncompensated service to the Selective Service System. Dr. Anderson is a past president of the association, founder of the *Mississippi Doctor,* and the 1968 recipient of the MSMA-Robins Award.

Orlando J. Andy of Jackson and the University Medical Center read a paper at the recent Louisville, Ky., sectional meeting of the American College of Suregons.

Richard L. Blount has announced the opening of his offices in the Medical Tower Building at 440 E. Woodrow Wilson Drive, Jackson, where he will limit his practice to ophthalmology.

Edgar E. Bobo of Pearl has been elected first chief of staff of the new 60-bed Rankin General Hospital near Brandon. John M. Estess of Florence is vice chief of staff, and Robert L. Peede of Brandon was named secretary-treasurer. E. L. Whitfield of Florence was installed as honorary chief of staff in recognition of his service to medicine. Executive committee members are Roland F. Samson of Jackson, Allen U. Hollis of Jackson, and Charles O. Williams of Pearl.

Andrew J. Carroll of Hattiesburg reigned as Zeus XXIX during Mardi Gras in the Hub City sponsored by the Mystic Krewe of Zeus. Miss Betty Barnes Moore of Hattiesburg, a senior at Ole Miss, reigned as queen.

Robert F. Carter of Biloxi appeared as principal speaker before the District 6 Nurses Association meeting recently at the Singing River Hospital, Pascagoula. A diplomate of the American Board of Urology, Dr. Carter received his medical education at the Tulane University and his specialty training at the Ochsner Foundation Hospital.

Walter W. Crawford of Tylertown has been appointed a member of the Mead Johnson Awards Committee of the American Academy of General Practice. The committee oversees awards of 12 fellowships in general practice each year carrying a stipend of $1,000 each. Dr. Crawford is president-elect of the Mississippi Academy of General Practice.

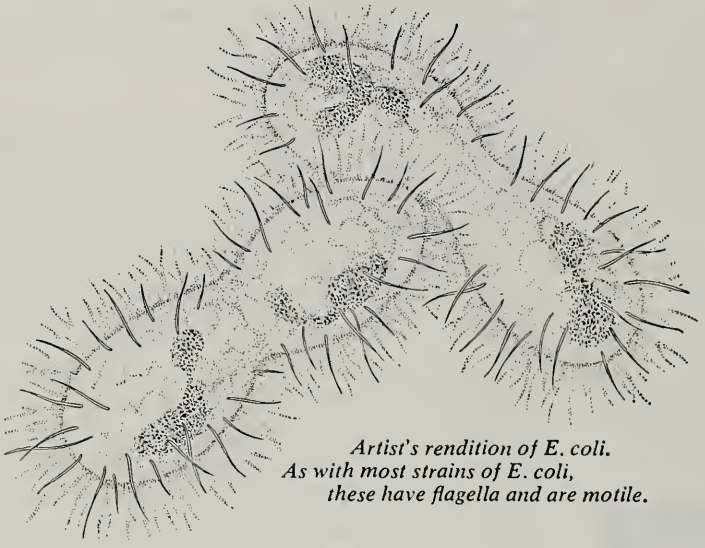
James E. Harris of Hattiesburg has announced the opening of his offices in the New Medical Plaza at 2601 Mamie St. where he will limit his practice to otology, laryngology, and maxillofacial surgery.

Charles M. Head of Jackson and Oney C. Raines, III, of Gulfport will be installed as Fellows of the American College of Obstetrics and Gynecology during the annual meeting April 28-May 1 at Bal Harbour, Fla. Candidates for Fellowship in ACOG must have been graduated from an approved medical school, received appropriate residency training, and limited their practice to obstetrics and gynecology for five years.

Donald E. Killelea of Natchez received a gift of $350 from the Lions Club for the Adams County Speech Therapy Clinic. The service facility has been in operation since 1957, assisting children in overcoming speech problems.

Ben J. Kitchings has been named to a four-year term on the Long Beach Municipal Separate School District board of trustees. He also serves as president of the Jefferson Davis Elementary School Parent-Teachers Association and has been

To help avert chronicity in acute cystitis



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

Although it may coexist with chronic pyelonephritis or prostatitis, many cases of chronic cystitis may result from incomplete treatment of a simple, acute cystitis. For this reason, it is being increasingly recommended that appropriate antibacterial therapy in full dosage be maintained for up to two weeks or longer.

Most frequently, the dominant pathogen is gram-negative, usually *E. coli;* most often, you will find Gantanol® (sulfamethoxazole) effective against *E. coli* and other sensitive organisms—gram-positive and gram-negative—commonly seen in cystitis and other urinary tract infections. Wide clinical usage of Gantanol has confirmed the efficacy of this wide-spectrum antimicrobial agent in the treatment of cystitis.

The rapidity of bacterial multiplication in a favorable urinary environment is well known. Prompt control of acute bladder infection is therefore essential

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended

not only to reduce the patient's discomfort but to prevent chronicity and possible ascending infection.

Gantanol (sulfamethoxazole) provides antibacterial activity within two hours of the initial 2-Gm dose, and subsequent 1-Gm doses, taken morning and evening, maintain therapeutic blood and urine levels lasting up to 12 hours. Significant symptomatic response is frequently achieved within 24 to 48 hours in acute, uncomplicated cystitis and other responsive urinary tract infections. In addition, Gantanol is usually well tolerated. Should prolonged therapy be required, the convenient *b.i.d.* dosage helps to minimize the problem of skipped doses.

Over eight years' clinical use has thoroughly demonstrated the qualities that make Gantanol a good choice for initial therapy of most urinary tract infections, including acute cystitis.

for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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Gantanol® B.I.D. (sulfamethoxazole)

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a member of the Harrison County Republican Executive Committee for five years.

DEWEY H. LANE, JR., has been named a member of the Pascagoula School Board. A general surgeon, Dr. Lane played a prominent role in the organization and chartering of the Singing River Medical Society last year.

LAWRENCE W. LONG of Jackson received his 50-year certificate from the Kappa Alpha Fraternity during a recent convivium at the capital city. A past president of the state medical association, Dr. Long is chairman of the Board of Trustees of the U. S. Section of the International College of Surgeons and chairman of the Committee on Publications of the state association.

J. PURVES MCLAURIN of Oxford has announced as a candidate for the Board of Aldermen for re-election in Ward 1. He is Mayor of Oxford *pro tem* and chairman of the city's recreation department. In the state medical association, Dr. McLaurin serves as secretary of the Section of Obstetrics and Gynecology.

CHARLES B. MITCHELL, JR., of Meridian has been named chairman for his area of the 23rd Annual Tulane Alumni Fund drive. A 1942 graduate of the Tulane University School of Medicine, Dr. Mitchell has conducted the kickoff meeting for all Tulane alumni in the Meridian area.

W. K. PURKS of Vicksburg has been elected president of the YMCA and has presided over the 1969 enrollment campaign meeting which drew the largest attendance of "Y" leaders and supporters in the history of the Vicksburg association.

T. ERSKINE ROSS, III, of Hattiesburg is serving as area chairman for the 23rd Annual Tulane Alumni Fund drive. He conducted the kickoff meeting with a dinner occasion where university needs and activities were highlighted.

EVERETT W. RYAN of Charleston has accepted an appointment as director of the Tallahatchie County Health Department, returning to the position which he first occupied 30 years ago. Following service in the Air Force in World War II, Dr. Ryan entered private practice. He recently resigned his partnership in the Charleston Clinic. Last month, citizens of the community sponsored a "Dr. Ryan Day" in appreciation of his services.

GRAY E. SCOTT, JR., has joined the staff of the Rush Foundation Hospital as Meridian. A native of Alabama, Dr. Scott was a jet pilot in the Air Force during the Korean War. He is a medical graduate of the Tulane University and received his postgraduate training at the New Orleans VA Center, Charity Hospital, and the Ochsner Foundation Hospital. He is a former faculty member at the Tulane School of Medicine. Dr. Scott will limit his practice to internal medicine and cardiology.

RALPH SNEED of Jackson appeared as featured speaker during the recent meeting of the Mississippi Chapter of the American Society of Safety Engineers. He limits his practice to otolaryngology.

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

BALLARD, JAMES LEE, JR., Tupelo. Born Tupelo, Miss., Dec. 7, 1938; M.D., University of Miss. School of Medicine, Jackson, 1964; interned same, one year; dermatology residency University of Ark. Medical Center, Little Rock, July 1, 1965-June 30, 1968; elected Dec., 1968 by Northeast Mississippi Medical Society.

BLAND, ANNA NELL, Laurel. Born Jackson, Tenn., April 12, 1921; M.D., University of Tenn. College of Medicine, Memphis, 1952; interned Scott-White Memorial Hospital, Temple, Texas, one year; pathology residency Lloyd Noland Hospital, Fairfield, Ala., 1953-56; Scott White Memorial Hospital, Temple, Texas, 1957-58; Baptist Memorial Hospital, Memphis, Tenn., 1958-60; M. D. Anderson Hospital, Houston, Texas, 1960-61; University of Tenn. Memorial Hospital, Knoxville, 1967; elected Dec., 1968 by South Mississippi Medical Society.

COOK, DONALD EUGENE, Meridian. Born Cromwell, Ala., Oct. 19, 1935; M.D., University of Miss. School of Medicine, Jackson, 1963; interned Mobile General Hospital, Ala., one year; orthopaedic surgery residency University Medical Center, Jackson, Miss., July 1, 1964-June 30, 1968; elected Jan. 1, 1969 by East Mississippi Medical Society.

GORDON, JAMES OTIS, JR., Tupelo. Born Memphis, Tenn., Feb. 9, 1939; M.D., University of

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FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

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methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Tenn. College of Medicine, Memphis, 1962; interned Charity Hospital, New Orleans, La., one year; surgery residency Kennedy V.A. Hospital, Memphis, Tenn., Jan. 1, 1964-Dec. 31, 1965; urology residency John Gaston Hospital, Memphis, Tenn., Jan. 1, 1965-Dec. 31, 1968; elected Dec. 3, 1968 by Northeast Mississippi Medical Society.

HENDERSON, JULIAN CROWDER, Jackson. Born Lawrenceburg, Tenn., Jan. 19, 1938; M.D., Tulane University School of Medicine, 1961; interned Jackson Memorial Hospital, Miami, Fla., one year; pathology residency Charity Hospital, New Orleans, La., 1962-66; elected Jan. 7, 1969 by Central Medical Society.

PATINO, CARLOS SAUL, Jackson. Born San Gil, Colombia, S. A., Aug. 12, 1937; M.D., National University of Colombia, Bogota, Colombia, S. A., 1962; interned Lutheran Hospital, Cleveland, Ohio, one year; anesthesiology residency Medical College of Virginia, Richmond, July 1, 1965-June 30, 1967; elected Jan. 7, 1969 by Central Medical Society.

SCHMIDT, ROBERT J., Biloxi. Born New Orleans, La., Aug. 7, 1937; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned Charity Hospital, New Orleans, La., one year; obstetric and gynecology residency same; elected Jan. 8, 1969 by Coast Counties Medical Society.

WANSLEY, BILLY MORRIS, Biloxi. Born Little Rock, Ark., July 12, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned Jackson Memorial Hospital, Miami, Fla., one year; residency Tulane University V.A. Hospital, New Orleans, La.; elected Jan. 8, 1969 by Coast Counties Medical Society.

DEATHS

BARRETT, IRWIN WILLIAM, Clarksdale. M.D., University of Virginia School of Medicine, Charlottesville, 1919; interned Kings County Hospital, Brooklyn, N. Y., one year; New York Postgraduate School, summers 1930, 32, and 35; died Feb. 2, 1969, aged 79.

BOX, WILLIAM EDGAR, Newton. M.D., University of Alabama, Tuscaloosa, 1912; interned part time at Charity Hospital, Mobile, Ala.; died Feb. 21, 1969, aged 83.

CHISOLM, JAMES JULIAN, Natchez. M.D., Johns Hopkins Medical School, Baltimore, Md.; taught at Johns Hopkins Medical School for 40 years; died Feb. 25, 1969, aged 79.

MCBRYDE, WILLIAM WALKER, Ethel. M.D., Memphis Hospital Medical College, Tenn., 1902; member MSMA Fifty Year Club and Emeritus member of MSMA; died Feb. 25, 1969, aged 95.

Medical Assistant Retires After 46 Year Service

Would you say 46 years as a medical secretary is enough? Mrs. Polly Shotwell of Jackson, thinks perhaps it is.

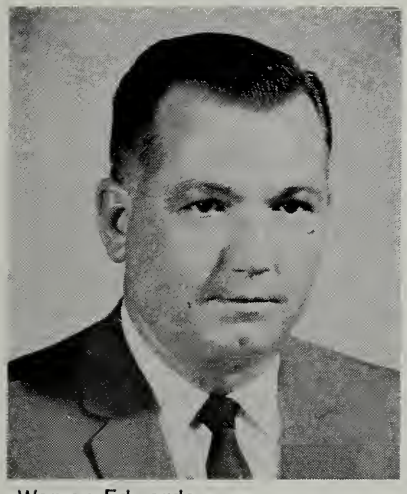
After serving the medical profession for two-thirds of her life, Mrs. Shotwell recently retired. A previously active member of the Central Mississippi Chapter of the Mississippi Association of Medical Assistants, she was awarded the organization's first honorary membership.

Speaking of MAMA, Mrs. Shotwell said, "I attended the first meeting as a guest of Dr. Wood when the organization plan was presented to the medical assistants by the Central Medical Society, and I have watched it grow and develop into a big thing. I was particularly interested when the doctors presented this to us; it would be such an educational and helpful thing to young girls starting in the medical field. I recall when I started in 1922, we had no educational help from any source except the training our doctors gave us in the office, and it was a hard road."

Mrs. Shotwell's first medical position was with Dr. Noel C. Womack, Sr., Jackson's first pediatrician. "I started in the roaring twenties—October 10, 1922—and would you like to know my starting salary? $35 a month! It was enough to pay my room and board, but when I had to have a pair of shoes to work in, I clerked on Saturdays at one of the department stores to make the money to buy them." When her salary was increased to $50 a month, it was a "tremendous occasion."

Mrs. Shotwell learned to write histories, give anesthetics, assist with spinal punctures, and other duties ordinarily performed by nurses today. Dr. Womack's office was in the old Jackson Infirmary on North President Street, and Mrs. Shotwell can tell many interesting stories of how, especially during World War II, she and Dr. Womack worked late into the night on many occasions on the hospital floors.

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Warren Edwards



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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, July 13-17, 1969, New York, N.Y.; Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo. E. B. Howard, Acting Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joseph B. Miller, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 1237, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Mary's Restaurant, Hernando, Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, August, October, December, and May 30. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. Edward Pennington, Ackerman, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, June, September, December, and March 8, 1970. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

Singing River Medical Society, Third Monday January, March, June, September, and December. Donald E. Dore, Singing River Hospital, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. W. B. White, 1007 Jefferson Street, Laurel, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

Masonite Gives $1.5 Million Medical Facility to the People of Jones County

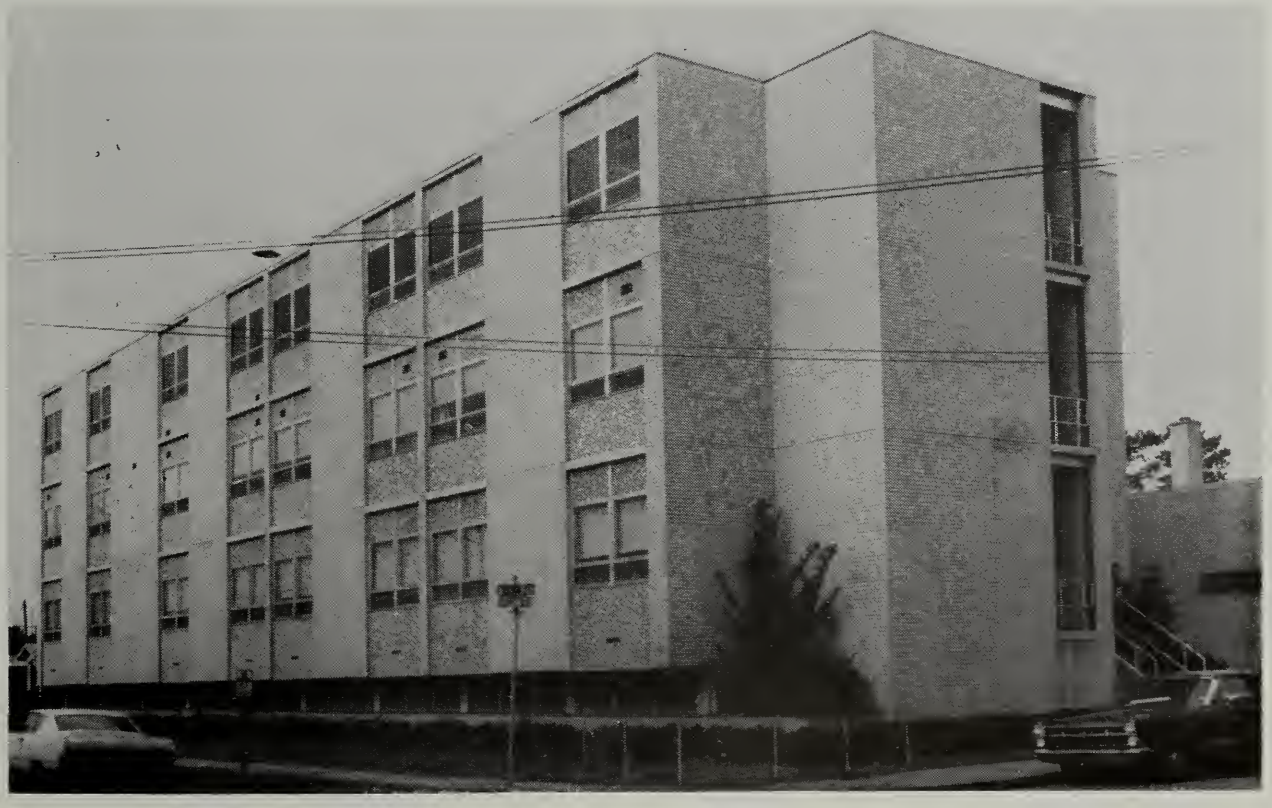
Amid appropriate fanfare, including a speech by Mississippi's Lt. Gov. Charles L. Sullivan, the Masonite Corp. presented its $1.5 million community medical center located in downtown Laurel to the people of Jones County.

Some 80 guests assembled in the hospital clinic Feb. 28 to see Masonite President John M. Coates unveil a plaque commemorating the presentation and hand over the title to the 60-bed facility to Herbert "Hub" Hosey, chairman of the Jones County Board of Supervisors.

"This hospital has served the employees of Masonite and local citizens well in the past," Coates said, "and it is with a great deal of sentiment that we relinquish such a good and trusted friend. This facility today becomes a public trust of the people and I know it will serve the people of this community well."

He explained there is no longer any need for the company to continue operation of a private medical facility since a new employee medical and hospital insurance program went into effect last year.

After the official presentation, guests were taken on guided tours of the medical center, which has one of the most modern operating rooms in the state. Later they were entertained at lunch at the Laurel Country Club.



The 60-bed Masonite Hospital, valued at $1.5 million, was presented by the owner-corporation to the people of Jones County in ceremonies at Laurel. Lt. Gov. Charles L. Sullivan was principal speaker on the special occasion.

Sullivan, who was principal speaker at the luncheon, congratulated Masonite for making such a generous gift, saying he could not recall any other company in Mississippi that had ever made such a presentation.

"We, and I feel I speak for the entire state, are deeply grateful to Masonite for this most worthwhile contribution to the people of Laurel and Jones County," Sullivan said. "Masonite has provided medical service to this area for years, and this contribution is most commendable."

The lieutenant-governor also referred to Medicaid, pollution, and the importance of good labor relations in his address.

Noting it was impossible to say at this time what will be done with the Medicaid program in Mississippi, Sullivan said the State's cost of the program could vary from $3 million to $21 million per year, depending on how it was set up.

"Mississippi is reaching the absolute ceiling on tax revenues, and I simply don't know today what will be done (about Medicaid) this year."

Governor John Bell Williams has said he is studying the question of calling a special session of the legislature to discuss setting up a state Medicaid program before the Jan. 1, 1970, deadline to retain federal assistance funds.

Sullivan also pointed out Masonite has launched a $10 million pollution program "to keep the environment of this area attractive and conducive to healthful living conditions."

The Masonite community medical center has provided medical care since 1932 for company employees and their dependents, as well as private care for many residents in the Jones County area.

The original clinic was in the O'Ferral Building in downtown Laurel which soon became inadequate. A building located on the corner of North Magnolia and Sixth Streets, across from Laurel General Hospital, was then purchased and used as a clinic for several years.

During this period, plans were developed to build a clinic on the present location. This was completed and put into service Feb. 17, 1941. Following World War II, with the increase in size of Masonite's Laurel plant and the shortage of physicians and hospital beds in the area, it became necessary to upgrade the hospital and add more physicians to the staff.

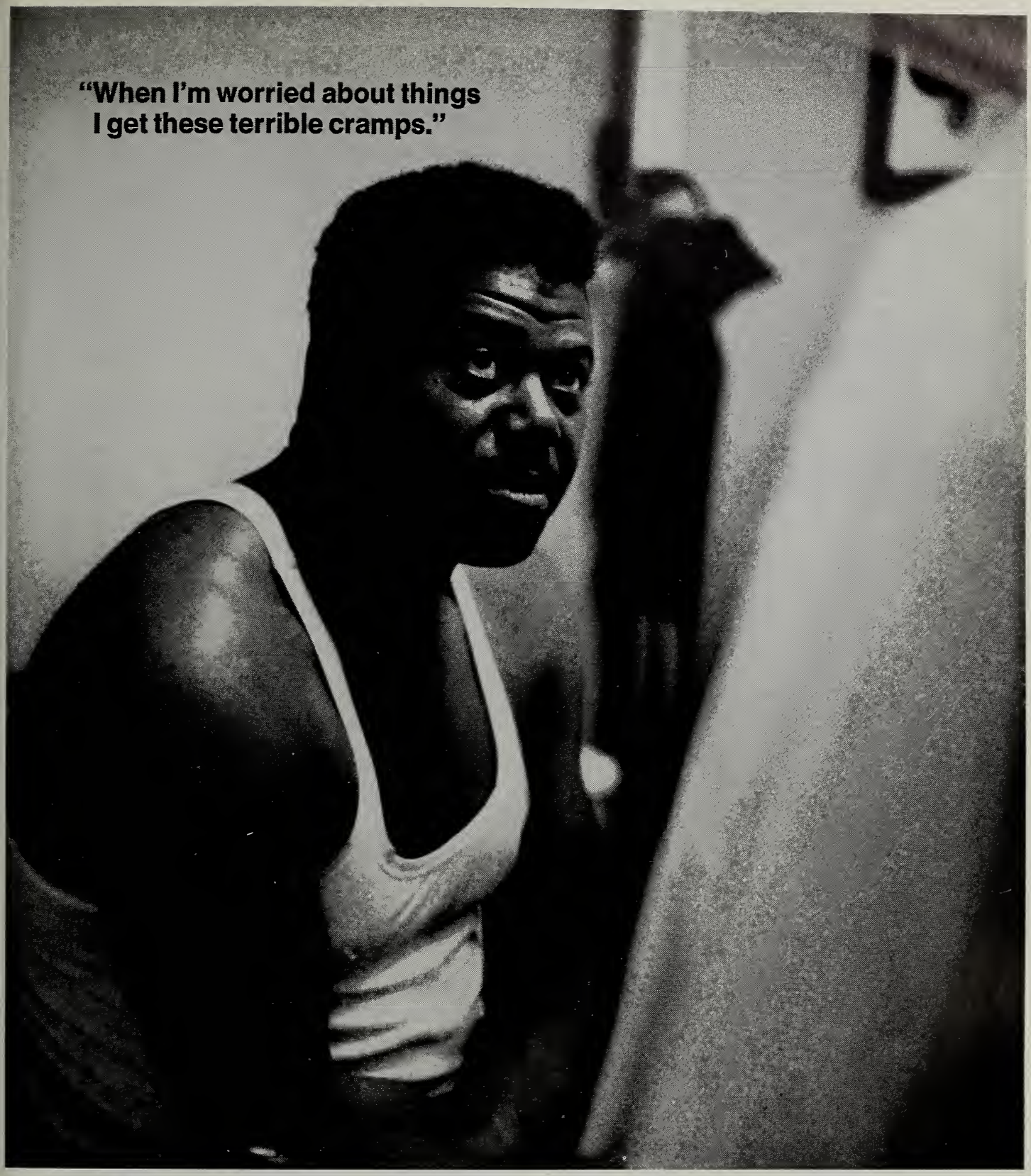
Four building additions have been made to the center since 1941. These were completed in 1948, 1954, 1962 and 1965. All were made by the company to keep up with its own growth and to provide adequate hospital and medical care for its Laurel employees.

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'MILPATH'-400: tridihexethyl chloride 25 mg. + meprobamate 400 mg.
'MILPATH'-200: tridihexethyl chloride 25 mg. + meprobamate 200 mg.

Usual Adult Dosage: 1 *'Milpath'-400* tablet, 3 times a day at mealtimes and 2 at bedtime. For greater anticholinergic effect, 2 *'Milpath'-200* tablets, 3 times a day at mealtimes and 2 at bedtime. Doses of meprobamate above 2400 mg. daily not recommended.
Contraindications: *Tridihexethyl chloride:* Urinary bladder-neck obstructions, e.g., prostatic obstruction due to hypertrophy; pyloric obstructions because of reduced motility and tonus; organic cardiospasm (megaesophagus); glaucoma; possibly in stenosing gastric or duodenal ulcers with significant gastric retention. *Meprobamate:* Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: *Tridihexethyl chloride:* Use cautiously in elderly males (possible prostatic hypertrophy). *Meprobamate:* Carefully supervise dose and amounts prescribed. Consider possible dependence or habituation (reported occasionally after excessive use), particularly in severe psychoneurotics, alcoholics, ex-addicts. Withdraw gradually (1 or 2 weeks) after excessive dosage for weeks or months to avoid recurrence of preexisting symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching; rarely, epileptiform seizures, more likely in those with CNS damage or latent convulsive disorders). If drowsiness or visual disturbance occurs, reduce dose and advise against activity requiring alertness (driving, machinery operation). Effects of excess alcohol may be increased. Grand mal seizures possible in persons with both petit and grand mal. Prescribe cautiously in small amounts to patients with suicidal tendencies. Prescribe with caution to patients with known sensitivity to compounds of similar chemical structure, e.g., carisoprodol.
Side Effects: The following side effects of components may occur with 'Milpath'. *Tridihexethyl chloride:* Severe effects rare on recommended dosage. Anticholinergic effects: dry mouth (fairly frequent at oral doses of 100 mg.), constipation or "bloated" feeling. Possible: tachycardia, dilation of pupils, increased ocular tension, weakness, nausea, vomiting, headache, drowsiness, urinary hesitancy or retention, dizziness. *Meprobamate:* Drowsiness, sometimes with ataxia, usually controlled by decreasing dosage, occasionally with aid of central stimulants (e.g., amphetamine). Rarely, allergic or idiosyncratic reactions (usually after 1-4 doses); in mild form: itchy, urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever, transient leukopenia, and 1 fatal bullous dermatitis (after meprobamate and prednisolone) reported. More severe, very rare hypersensitivity: fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal), anuria, anaphylaxis, stomatitis and proctitis. Treat symptomatically (e.g., epinephrine, antihistamines, possibly hydrocortisone); stop and do not restart the drug. Isolated agranulocytosis, thrombocytopenic purpura, 1 fatal aplastic anemia reported, but only in presence of known toxic drugs; porphyric symptoms reported but relationship not established. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation reported by 1 observer. Fixed drug eruption with meprobamate and cross reaction to carisoprodol reported. Suicidal attempts may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Excessive dosage has led rapidly to sleep, then reduction of vital signs to basal levels. Empty stomach, and if respiration becomes very shallow and slow, cautiously give CNS stimulants (e.g., caffeine, pentylenetetrazol, amphetamine); also pressor amines if indicated.
Before prescribing, consult package circular.

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See adjacent page for brief summary of prescribing information.

GP Board Becomes 20th Certifying Body

A new specialty of family medicine was officially recognized by organized medicine when the Advisory Board for Medical Specialties and the Council on Medical Education of the American Medical Association approved a specialty board in family practice. The medical regulatory bodies met at the Palmer House in Chicago.

The new specialty, the 20th of the profession's primary groups, brings medicine full-circle since the trend toward specialization began after World War II. Before that, most doctors were G.P.'s, or family doctors. With creation of the specialty of family medicine, the family doctor now can become a specialist in his own right.

The Advisory Board approved a revised application for specialty status submitted by the American Academy of General Practice and the Section on General Practice of the AMA.

The new American Board of Family Practice is empowered by the decision to conduct examinations and to grant specialty certification to family physicians who meet its qualifications and pass the examination. This certification will be recognized by the American Medical Association and other jurisdictional bodies in medicine, just as other specialty groups are recognized.

The new specialty grew out of the classic general practice on which modern scientific medicine was founded, Dr. Maynard I. Shapiro of Chicago, AAGP president said. He described it as an evolutionary development reflecting the changing pattern of American society, shifting population trends, changing public attitudes and demands, more specific standards and criteria for professional function, and the medical profession's recognition of its responsibility to devise a practical response to the nation's rising health care needs.

Official sanction of the new specialty is expected to increase the attractiveness of primary medical practice to young doctors. A basic problem in American health care has been a shortage of physicians and, more specifically, a severe shortage of physicians to serve the first-line doctors.

"This is not just old-time general practice with a new name, however," Dr. Shapiro said. "We, and the many medical educators and traditional specialists who have been helping us, feel strongly that a true discipline has been identified, that its perimeters have been defined, and that a specific body of knowledge in a vital and needed area of medicine has begun to develop.

"This form of practice is built on the solid foundation of general practice but takes off dramatically from there into the important areas of behavioral science and the vital but little-understood health factors in environmental and interpersonal relationships. It is true that many old-time family doctors dealt in these factors without even realizing it; today we can teach it, and this is what the new specialty is about—teaching young doctors to practice in a scientific context those things that made the best of the old-time general practitioners great."

The Advisory Board for Medical Specialties' Liaison Committee deferred an earlier application last February. The revised application incorporated a new group of "Essentials for Graduate Training in Family Practice" approved by the AMA's Council on Medical Education and, at its last meeting, the House of Delegates of the AMA. Currently, there are 32 residency training programs actually in operation or in development in medical schools and hospitals. The new specialty board requires three years of residency training for eligibility to take the certification examination.

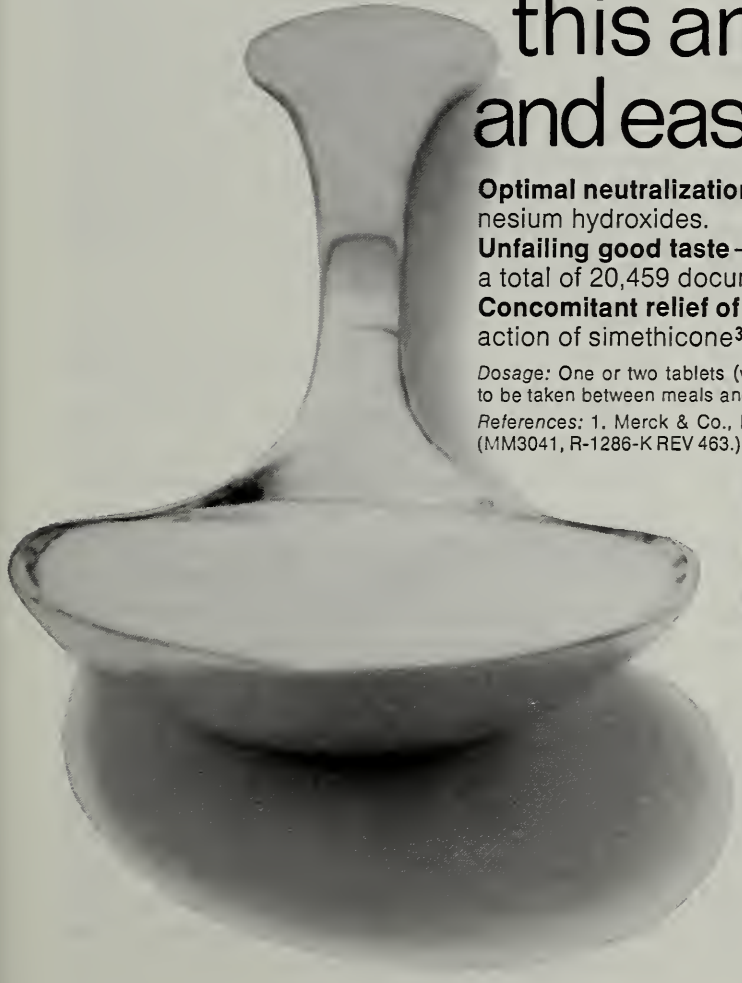
Family doctors now in practice will be eligible to take the examination upon showing evidence of having completed a minimum of 300 hours of accredited postgraduate study in medicine. As a practical matter, in most cases this would mean having been a member of the Academy of General Practice for a period of six years. The AAGP, second largest U. S. medical organization, requires its 31,000 members to complete a minimum of 150 hours of approved postgraduate study during each three-year membership period. It is the only national medical organization with such a requirement.

The bylaws of the new board call for a termination of the "practice-eligible" category in 10 years, so that after that period only graduates of approved family practice residencies will be eligible for certification. There is no provision for "grandfathers"—certification can be achieved only by passing the examination—and periodic recertifications, also by examination, will be required. No other specialty board has a recertification provision.

The examination, Dr. Shapiro said, is ready to be given now. It was prepared by the National Board of Medical Examiners, Philadelphia, which designs most similar examinations for medical specialty boards, state licensing boards, and others. Dr. Shapiro added that the new board will begin offering the examinations as quickly as possible.

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References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.

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discrimination and for providing a constitutional means for expulsion of a state medical association found in repeated violation of such discrimination. The amendment was narrowly adopted by a margin of only three votes.

Ninety-four items of business, including 62 resolutions and 22 reports of the Board of Trustees, were considered. Subject areas paralleled closely those of the San Francisco annual convention. Further definitive actions were taken on the absorption of osteopathy into medicine with special recommendation for strengthening the curricula of schools of osteopathy toward the end of upgrading them to medical schools eligible for AMA accreditation.

President Dwight L. Wilbur urged a five-point program in his presidential address, calling for high quality medical care for all Americans at the most reasonable possible cost, putting a rein on care costs by careful and diligent utilization of hospitals, developing more reasonable and more realistic expectations by the public, unifying the profession and maintaining constructive liaison with other groups, and planning for an orderly and enhanced future for medicine. The House again urged enactment of tax credits for the purchase of health insurance and asked that AMA vigorously promote such a federal enactment. Impetus will be given to care cost studies under another House action.

Recognizing that advertising and promotion of new Blue Shield programs providing broader benefits might be subject to misinterpretation by the public, the House resolved that "any reference to paid-in-full coverage clearly identify those services which indeed are covered on a paid-in-full basis and also identify the circumstances under which those services must be rendered."

The policy statement on transplantation of human tissue and the ethical implications inherent in such procedures were amplified by the Judicial Council. The action asked that the evolution of the therapy be orderly and that any major medical center undertaking such procedures be fully prepared by training, research, and experience in immunosuppressive therapy to do so.

The House agreed that there is need for physician prescription and supervision of all ancillary services provided in the hospital. The policy states that "the medical staff should concern inself with contractual agreements between various allied health professionals and the hospital only insofar as, and to the extent that, such agreements tended to remove the provision of ancillary services from the prescription and supervision of the physician."

Other actions urged AMA to seek to have the Congress phase out federal health care programs which overlap and duplicate Title XIX Medicaid and to amend the Comprehensive Health Planning Act to permit "a substantial percentage" of planning boards and councils to be practicing physicians.

AMA was asked to provide leadership in sponsoring public affairs workshops for the benefit of state and component society leaders, and the House resolved to "exert every effort to bring about the elimination of unnecessary documentation of medical services by the physician, hospital, and fiscal intermediary on Medicare and Medicaid patients."

Dr. F. J. L. "Bing" Blasingame, former Executive Vice President, addressed the House calling for a constitutional convention to re-evaluate the working of the AMA and to equip it better for the Herculean tasks it faces. His remarks were statesmanlike, serious, and forwardlooking. Three resolutions commending his service as a Delegate, Trustee, and Executive Vice President were adopted.

Expression of Delegates. Your Delegates to AMA express their appreciation to the state medical association's Board of Trustees and general officers for support and the maintenance of continuing communication in the guidance of our representation. We sit with the Board at all meetings, and we are thereby enabled to be fully informed on association policy and positions. We pledge our continued best effort in representing the desires, wishes, and policies of the association in the AMA House of Delegates.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

100th Annual Session. At the 100th Annual Session in 1968, your Council on Constitution and By-Laws considered four amendments to the By-Laws. Two were adopted by the House of Delegates and two failed to pass.

Section 4(c), Chapter I, was amended to permit the association to furnish the Journal without charge to members of the association who are exempt from dues by reason of service in the Armed Forces other than as regular officers.

Section 2, Chapter VI, was amended to provide for a substantially altered nominating process.

101st Annual Session. There are presently no pending amendments to the Constitution or By-Laws. Your council will hold itself in readiness to consider any proposed amendments which may be brought before the House of Delegates at the 101st Annual Session.

Constitutional Responsibilities. Your Judicial Council is one of eight elected councils of the association and one of the three which reports directly to the House of Delegates. Under the provisions of Section 4, Chapter IX, By-Laws of the association, the council is charged with exercise of the judicial powers of the association and interpretation and application of the *Principles of Medical Ethics of the American Medical Association*. The rulings of the council are subject to the will of the House of Delegates, and its judicial decisions may be appealed to the Judicial Council of the American Medical Association.

In 1960, this House of Delegates approved the council's proposals as to procedural authorities with reference to controversies or actions involving members of the association. These rules of procedure were reviewed during the 1968-69 association year, and your council recommends no change.

Council Activities. The council is glad to report that there were no matters at controversy involving members or component medical societies of the association before it during the 1968-69 association year. The council, in an effort to be of service to the association, addressed itself exclusively to matters of medical ethics.

The council was fortunate in having the opportunity to meet with Edwin J. Holman, LL.B., of Chicago, secretary of the Judicial Council of the American Medical Association. Mr. Holman came to Mississippi on our invitation and met with the council on Oct. 30, 1968. His advice and counsel have been most valuable in our deliberations.

Our state medical association executive office has secured for each member of the council a complete set of Opinions of the Judicial Council of AMA through 1968, and we are regularly receiving copies of new opinions as they are issued.

Medical Ethics. The Judicial Council has issued opinions in a number of areas of medical ethics and submits these opinions to the House of Delegates for the guidance of the membership:

(a) *Telephone Directory Listings.* It is preferable for a physician's name to be followed by the designation "M.D." in telephone directories rather than to be preceded by the designation "Dr." The latter can be confusing, since it is a designation claimed by those who are not physicians. In classified sections of telephone directories, physicians' names should be listed alphabetically, and the size and face of the type should be uniform. The component medical society should establish such guides in this connection as are deemed appropriate and assure service to the public through locally acceptable telephone listings.

(b) *Compulsory Assessments.* Compulsory assessments upon members of a hospital medical staff, that is, assessments which if not paid might cause the physician to lose staff membership, are not in the best traditions of ethical practice. It is not proper to condition medical staff membership on compulsory assessments for any purpose.

(c) *Transplantation of Human Tissue.* When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests. Transplantation of body organs should be undertaken only by physicians who possess special medical training, study, and laboratory experience and practice and in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

(d) *Drugs and Devices.* Ownership of shares in a pharmaceutical manufacturing company by a physician is not unethical when the physician cannot and does not exercise control over the company or permit it to influence his choice of drugs. It is unethical for a physician to own shares in a drug repackaging house.

(e) *Treatment of Obesity.* Management of obesity is a difficult medical problem requiring the utmost in cooperation between patient and physician with full consideration for the individual patient's needs medically. The use of so-called "rainbow pills" in the treatment of obesity and the so-called shotgun prescribing of cardiac glycosides, thyroid hormones, diuretics, anorexiants, barbiturates, amphetamines, and laxatives for the overweight is to be condemned. Use of cardiac glycosides and thyroid extracts in so-called "rainbow pill" regimens are to be especially condemned.

(f) *Laboratory Services.* Laboratories operated in the name of a physician who spends a small portion of his time in its direction and those operated by nonphysicians raise frequent questions. Some are good, and some are poor. Often, the appeal of these laboratories, especially those out-of-state, is economic. A physician's responsibility to his patient is to provide quality services, including those personally performed and those delegated to consultants. Medical judgment based on inferior laboratory work is likewise inferior. A physician is responsible for his diagnosis and treatment, and caution should be exercised with the understanding that difficult situations could result in instances of professional liability with some out-of-state laboratories.

(f) *Bank Credit Cards.* Since bank credit cards

are substitutes for cash or checks, it is not unethical for a physician to participate in a bank card program. The component medical society should satisfy itself as to the financial and professional integrity of the plan and assure that service charges to physicians are reasonable. The individual physician may not, because of his participation, increase his fee, and he may not encourage patients to use the cards. His position is that he accept the card as a convenience to patients who desire to use it. Plaques, signs, and other devices indicating participation in a bank card plan in a physician's office shall be kept to a discreet and dignified minimum. Such signs outside the physician's office are unacceptable. Use of bank card in connection with payment of larger fees which might normally be paid to the physicians in installments is not to be encouraged. The patient who elects to use a bank credit card for payment of medical fees should be encouraged to pay on the first billing by the bank card service so as to avoid interest charges.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted seven meetings since the 100th Annual Session when this report is considered by the House of Delegates. The Board met in May, twice in August, and in December of 1968. In 1969, the Board met in February and has meetings scheduled in April and May. Altogether, the seven meetings included nine meeting days, usually exclusive of travel.

This annual report includes actions on matters referred by the House of Delegates and those items relating to management and policy functions which are among the Board's responsibilities.

Referrals from the House of Delegates. Matters referred by the House of Delegates at the 100th Annual Session and actions by the House requiring consideration by the Board of Trustees include:

(a) *Amendment to the By-Laws, Journal.* On recommendation by the Board, the House of Delegates amended Section 4(c), Chapter I, to permit furnishing the JOURNAL without charge to members of the association who are exempt from dues by reason of service in the Armed Forces of the United States other than as a member of the regular establishment. The Board has implemented this amendment, authorizing the Executive Secretary to furnish such JOURNAL subscriptions.

(b) *Amendment to the By-Laws, Nominations.* Section 2, Chapter VI, was amended to alter the nominating process substantially, selecting the Nominating Committee one year in advance and requiring the committee to conduct formal meetings at least three months prior to the annual session at which elections are to be held and to publish the slate of nominees at least one month prior to the annual session. The committee members are also required to consult the membership in their respective districts and societies and prospective nominees as to their willingness and ability to serve, if elected. This amendment has been implemented, and the slate of nominees is being published in the April 1969 issue of the JOURNAL and in the Handbook of the House of Delegates.

(c) *New Component Medical Society.* The House of Delegates approved the Board's action on a petition from the physicians of Jackson County for chartering of a new component medical society. On Nov. 6, 1968, formal ceremonies were conducted at Biloxi during the annual meeting of the Coast Counties Medical Society during which the charter was presented to the Singing River Medical Society to become effective Jan. 1, 1969. The President, assisted by the Chairman of the Board, made the presentation, and the Board of Trustees welcomes the new society as the 18th component of the association.

(d) *Fee Review.* The House of Delegates requested that the Board of Trustees offer "such services as may be made available to component medical societies in organizing and establishing fee review committees." In implementing this action, the Board made guides available for organization and operation of fee review committees, and the President communicated with each society requesting local implementation. In addition, the President addressed a number of societies on fee review activities, and additional mailings were made to the societies in this connection. The Board emphasizes the importance of fee review and again encourages each society to maintain an active, working committee to assure that this function remains within medical organization.

(e) *Resolution No. 2.* The House adopted Resolution No. 2, subject: Office of County Coroner, introduced by the Homochitto Valley Medical Society, which states that the association affirm its belief that coroners should be licensed doctors

of medicine and that the association seek appropriate legislation to accomplish this objective. Implementation of the resolution consisted of active support of H.B. 1110 in the 1968 Regular Session of the Legislature which was finally enacted on July 9, 1968.

(f) *Resolution No. 3.* Adoption of this resolution reaffirmed the association's endorsement of the Health Insurance Council uniform claim form and encouraged component medical societies of the association to endorse use of the form in submission of health insurance claims. The action also asked that local societies establish liaison with representatives of the health insurance industry to assure understanding of the form's use and application and that appropriate publicity be afforded the action in the JOURNAL. The Board has implemented these actions, and the association continues to furnish members pads of the HIC uniform claim forms at cost. The Mississippi Health Insurance Council has given the association its pledge of cooperation, and virtually all major carriers are accepting the claim form. Since adoption of the resolution, the Mississippi Hospital Association, noting the action of our House of Delegates, adopted a similar resolution as the form applies to hospitals.

(g) *Resolution No. 5.* This resolution urges repeal of the 1966 amendments to the Public Health Laws providing for an optometric member of the State Board of Health. In recommending adoption of the resolution, the reference committee at the 100th Annual Session stated that "we stress in this regard that it will take the same type grassroots support by our association to repeal this law as provided by the association (Mississippi Optometric Association) which got the law passed in 1966." Because of other critical legislation relating to optometry and related fields in the 1968 Regular Session, the late date of the action at the 100th Annual Session, and the fact that a new State Health Officer was being appointed, action legislatively was not practical or possible. The Board has consulted the State Board of Health in this connection, and the matter is still pending actively.

(h) *Resolution No. 6.* Adoption of this resolution carried the mandate that the association "urge its component medical societies and each of its members to support such a statewide (tetanus) education and immunization program." Implementation was highly successful, with several societies and local medical communities sponsoring tetanus immunization programs. In concert with the Mississippi Chapter, American College of Surgeons, a major article in this connection was published in the JOURNAL, and editorial support was also given the program. Additionally, the views of the Committee on Occupational Health on immunization against tetanus, previously made a matter of policy, were again publicized.

Official Travel. On recommendation by the Council on Budget and Finance, the Board of Trustees has drawn and promulgated "Guidelines for Authorization, Performance, and Reimbursement of Official Travel in Behalf of the Mississippi State Medical Association." The guides provide for (1) determination and approval for official representation as to necessity and value to the association, (2) selection of representatives, except in instances where other means of selection prevail, i.e., AMA Delegates as representatives at AMA conventions, (3) formal reimbursement policies, and (4) uniform expense vouchers requiring full documentation. In most instances, the Board reviews requests for travel in advance of the trip. All who ordinarily perform official travel have been furnished copies of the guides, and councils and committees desiring to send representatives on official travel are now submitting such requests to the Board of Trustees.

Insurance Programs. The association sponsors three major insurance programs for the membership, consisting of a wide range of plans by the Continental Companies which are administered by Thomas Yates and Co. of Jackson, a professional liability insurance program underwritten by the St. Paul Companies, and a Blue Cross hospital contract.

(a) *Continental Programs.* These plans include accident and health, income replacement, catastrophic hospital expense, life and 65 sickness and accident, various Medicare supplements, accidental death and dismemberment, and group life insurance. Experience has proved satisfactory in all but one plan, the catastrophic hospital expense. With highly adverse experience over the past two years, the company has found it necessary to revise the rate structure upward.

(b) *St. Paul Program.* The crisis in professional liability insurance nationally underscores the desirability of an association-managed program such as has been conducted with the St. Paul Companies since 1961. With professional liability insurance premium rates now at record highs, i.e., $925 for 5/15 surgical coverage in California, the Board of Trustees has re-emphasized its close and continuing supervision of this vital service. The Mississippi rate is the lowest in the nation, and the Board believes that the claims review service available to the membership has been an important factor in this respect. The Board empha-

sizes the importance of sufficient professional liability insurance coverage, suggesting that each member consider carefully umbrella coverage in addition to his regular contract.

(c) *Blue Cross Group.* The association's Blue Cross hospital group was upgraded to type 122X contract from the former type 71X contract, thereby increasing the daily room allowance to $20 from $12 and increasing the number of days per confinement covered to 100 from 90. The upgrading resulted in net increases in monthly dues (premiums) of $1.88 single, $4.66 two party, and $5.49 family. A separate supplemental report relating to nonduplication of Medicare benefits is being submitted to the House of Delegates.

The Board of Trustees reviews each of these insurance programs in detail, requiring full data as to income, earned premium, type and extent of benefit payments, participation, incurred loss, reserves, and actuarial information from the carriers. Regular liaison is also conducted in behalf of the Board on a continuing basis by the Executive Secretary.

Appointments. Under the provisions of Section 1, Chapter VII, By-Laws of the association, the appointive powers are vested in the President. During the 1968-69 association year, President Rogers made the following appointments, each of which has the endorsement of the Board of Trustees:

(a) *Vice Speaker.* After his election to the office of President-elect at the 100th Annual Session, Dr. James L. Royals of Jackson expressed the wish that he not continue in a dual officer role, having been elected Vice Speaker in 1967. The President and Board accepted Dr. Royals' wish, and President Rogers appointed Dr. John B. Howell, Jr., of Canton Vice Speaker to serve the unexpired term until 1970.

(b) *Council on Medical Education.* Dr. R. Mayo Flynt of Meridian resigned as a member of the Council on Medical Education, and President Rogers appointed Dr. Frederick E. Tatum of Hattiesburg to serve the unexpired term until 1970.

(c) *MPAC.* Vacancies on the Board of Directors of the Mississippi Medical Political Action Committee were filled as follows: District 2, Dr. Eddie E. Bramlitt of New Albany and District 6, Dr. E. E. Robinson, Jr., of Meridian. Each term is for one year.

(d) *Nominating Committee.* One death and one resignation required appointments to the Nominating Committee which became a continuing body under amendments to the By-Laws at the 100th Annual Session. Dr. John G. Egger of Drew was appointed District 1 member, succeeding the late Dr. E. LeRoy Wilkins of Clarksdale, and Dr. James T. Thompson of Moss Point was named District 9 member, succeeding Dr. B. B. O'Mara of Biloxi who resigned for reasons of health. Dr. Thompson also succeeded Dr. O'Mara as chairman.

(e) *Council on Constitution and By-Laws.* President Rogers appointed Dr. William T. Wilkins of Clarksdale to succeed his brother, the late Dr. E. LeRoy Wilkins, as a member of the Council on Constitution and By-Laws, term to 1969.

Nominations. As required by law, the House of Delegates selected five nominees for one vacancy on the Board of Trustees of Mental Institutions. The nominees are Drs. J. A. K. Birchett of Vicksburg, Eldon L. Bolton of Biloxi, C. P. Crenshaw of Collins, Martin E. Hinman of Vicksburg, and the incumbent, Victor E. Landry of Lucedale. These physicians were formally nominated to Governor John Bell Williams immediately following their selection at the annual session. There were no vacancies to fill on the Mississippi State Board of Health.

Organization of the Board. Two new members of the Board were welcomed for the 1968-69 association year, bringing to a total five new Trustees from 1967 to 1968. Dr. William O. Barnett of Jackson succeeded Dr. John B. Howell, Jr., of Canton as District 5 Trustee, and Dr. Guy T. Vise of Meridian succeeded Dr. Lamar Arrington of the same city as District 6 Trustee.

The President, President-elect, Secretary-Treasurer, Speaker, Vice Speaker, and the two AMA Delegates sit with the Board in all meetings. Officers of the Board of Trustees during 1968-69 are Drs. C. D. Taylor, Jr., of Pass Christian, Chairman; J. T. Davis of Corinth, Vice Chairman; and Mal S. Riddell, Jr., of Winona, Secretary.

SUPPLEMENTAL REPORT "A" OF THE BOARD OF TRUSTEES

Amendment of Society Charter. The membership of the Homochitto Valley Medical Society, acting under its own Constitution and By-Laws as well as those of the state medical association, has acted formally to seek amendment of its charter, redesignating the organization as the Adams County Medical Society. The membership feels that the new designation is a more appropriate identification of the society.

A formal petition to this effect, submitted under the provisions of Section 1, Chapter XII, By-

Laws of the association, has been reviewed and approved by the Board of Trustees. In the formal action and submission of the petition, the officers and members of this component medical society have properly fulfilled all requirements prescribed by the Constitution and By-Laws.

Accordingly, the Board of Trustees approves the amendment to the charter redesignating the organization as the Adams County Medical Society and recommends concurrence by the House of Delegates. The society remains assigned geographically to District 8, and the amendment to the charter should be effective upon approval by the House of Delegates.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties. The Council on Medical Service is a constitutional body of the House of Delegates. It is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under its jurisdiction there are assigned the activities of the association in Medical service, emergency service programs, indigent care and allied medical agencies. The council is assisted in its work by three constitutional and three ad hoc committees. Programs, studies, and activities of the council's several committees embraced a wide range of subject areas and policy development during the 1968-69 association year.

Committee on Maternal and Child Care. The committee has continued its study and evaluation of maternal deaths occurring in Mississippi. As of March, 1969, the committee had sent out 563 inquiries on maternal deaths since its study began in January, 1958. Replies to these inquiries continue to occur in 83 per cent of the cases. The committee's IBM study program of the maternal deaths reviewed by the committee has continued to the point where a special scientific paper entitled "Cause and Treatment of Maternal Mortality Due to Hemorrhage—A Ten Year Study" will be presented on the scientific program at the association's 101st Annual Session. In the near future the committee will present other major scientific papers developed from its IBM study data on maternal deaths. A scientific exhibit is also being considered by the committee for presentation in this connection.

Following up on the committee's report to the House of Delegates last year concerning the development and publication of a set of "Maternal Health Desk Cards" for distribution to hospitals in the state, the committee wishes to report that a card booklet was sent to each hospital chief-of-staff in the state during the past summer with a cover letter explaining the cards and a reorder form. Based upon an initial mailing of 136 sets of the cards, the committee received requests for an additional 323 sets from hospitals throughout the state.

Committee on Mental Health. This committee has responsibility in the broad field of mental health activities. During the past year members of the committee have met with public and private agencies whose programs are concerned with mental health activities. The chairman of the committee officially represented the association at the 15th Annual Conference of State Medical Association Mental Health Committees, sponsored by the AMA, March 14-15, 1969.

Committee on Occupational Health. This committee has responsibility for studying all aspects of occupational health in Mississippi. As a follow-up to its "Study of Occupational Health Programs in Small Plants in Mississippi" presented to the House of Delegates in 1967 the committee has reported that it will develop a guide for occupational health programs in small plants in Mississippi.

The committee has continued publication of a series of articles in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concerning various subjects in the field of occupational health and in this connection the second article in the series titled "Responsibilities of the Physician in Workmen's Compensation Cases" appeared in the May 1968 issue of the JOURNAL. The committee also reports that a legislative goal of the committee and the association to include occupational disease coverage in the Mississippi Workmen's Compensation Act was accomplished during the 1968 Regular Session of the Mississippi Legislature with amendment of the act for this purpose.

Committee on Nursing (ad hoc). This committee has responsibility for conducting a program of active liaison with the Mississippi Nurses Association. During the 1968-69 association year the committee has met with its counterpart from the Mississippi Nurses Association for discussion of three topics of interest and concern to the two professions. They are: (1) Accreditation of New Nursing Schools in Mississippi; (2) Clinical Training for Nurses and Coordination of Nursing Training in Mississippi; and (3) Mandatory Licensure for R.N.s and L.P.N.s in Mississippi. The committee's recommendations with respect to the subjects of accreditation and mandatory licensure will require policy actions by the House of Delegates and therefore will be covered in a special supplemental report to the House of Delegates. In regard to the subject of training for nurses,

the committee recommends that the association encourage hospitals in the state to establish formal inservice training programs for new R.N.s and L.P.N.s.

The committee also reports that a nursing education advisory group has been named by the Board of Trustees of Institutions of Higher Learning and that the chairman of the committee serves with this group.

Health Insurance Benefits Advisory Committee (ad hoc). This committee was established by the council to act as a fact-finding and advisory committee on operation of the Medicare Program in Mississippi. The committee also serves as an advisory committee to the Medicare Unit of the Mississippi State Board of Health and during the 1968-69 association year the committee has met with representatives of this agency and the Travelers Insurance Company and other fiscal contractors for Medicare in Mississippi. The committee has served to bring physicians' inquiries concerning professional fee allowances under Medicare to the attention of the Medicare fiscal contractor for professional services—the Travelers Insurance Company. Each inquiry has been handled with dispatch and courtesy by Travelers' representatives and the committee expresses its appreciation for this. In turn the committee has offered professional advice to Travelers' representatives upon request.

In its role as professional advisory committee to the Medicare Unit, Mississippi State Board of Health, the committee has reviewed certain professional aspects of utilization review in extended care facilities. The committee proposes that this subject area be the object of a series of meetings sponsored by the Mississippi State Board of Health and this proposal will be covered in a supplemental report to the House of Delegates.

Committee on Blood and Blood Banking (ad hoc). This committee continues to monitor all aspects of blood banking and transfusion service, blood products, and professional and socioeconomic policy in this connection. During the 1968-69 association year the committee has been particularly concerned with problems of donor recruitment and blood replacement and the need for both public and professional education concerning this subject area. The committee formulated a program on this subject which was presented at a recent meeting of the Central Medical Society. The major presentation at the meeting will appear in the Journal of the Mississippi State Medical Association and the committee has offered to present a similar program at other component medical societies when requested.

The committee has also studied a proposal to conduct a pilot blood information program in the Jackson area which would utilize the association's new 360/20 IBM computer. The program, when finally formalized, will be presented to the Board of Trustees and House of Delegates for approval.

Activities of the Council. In addition to the work of its several committees, the council has considered and acted upon other items of medical service interest. These will be the subject of a special supplementary report to be presented to the House of Delegates.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates. It is charged with the responsibility of planning the annual sessions of the association to include all scientific activity and the programming and scheduling of annual session events. The council membership consists of the chairmen and secretaries of the several scientific sections and the secretary-treasurer of the association.

101st Annual Session. Your council began planning for this 101st Annual Session of the association at a meeting in Biloxi last Augst, 1968. The council has sought to continue a general scientific format in the context of meeting by specialty sections. Additionally the council has requested and placed scientific speakers on the several specialty sections from specialty societies not represented on the council.

The council is happy to report that twelve specialty society groups will be meeting during this 101st Annual Session. Additionally, medical alumni groups of four medical schools will be conducting functions. The council continues to emphasize that this combination of meetings benefits all groups as they compete for the time and attention of the busy practitioner.

Your council has again this year scheduled film programs preceeding each of the scientific sections. The council believes that a variation in programming and format for our scientific sessions is important in establishing and continuing good attendance at the sessions and in this connection. your council will be viewing the feasibility of conducting special scientific seminars and round table scientific seminars at future annual meetings of the association.

Your council has also acted to continue sponsorship of the annual "Aesculapius Award for Sci-

entific Achievement" given to that member of the association presenting the most outstanding scientific exhibit. From 1966 through 1968, this award was sponsored by Mead Johnson Laboratories. There has been an increase in both the quantity and quality of scientific exhibits since inception of the award.

Expression of the Council. Your council is deeply grateful for the support, assistance, and cooperation which we have received in planning the 101st Annual Session. We hope that this meeting will be professionally profitable and personally enjoyable to all.

RESOLUTION NO. 1, IN MEMORIAM

This resolution will be presented by the Secretary-Treasurer at the opening meeting of the House of Delegates on May 12, 1969. It has the purpose of memorializing and recording the deaths of all members of the association since the 100th Annual Session.

RESOLUTION NO. 2, PROFESSIONAL COMPENSATION FOR AUTOPSY, IN BEHALF OF THE PRAIRIE MEDICAL SOCIETY

WHEREAS, Existing state law limits payments to pathologists for autopsies ordered by a coroner or other proper authority, and

WHEREAS, The amount authorized by law is $75 or less, and

WHEREAS, It is believed that this is an inadequate compensation for the professional services involved, now, therefore, be it

Resolved, That the House of Delegates of the Mississippi State Medical Association seek amendment to existing law to provide for more proper and adequate professional compensation for this medical service.

RESOLUTION NO. 3, JAMA LABORATORY ADVERTISING BY LEO J. SCANLON, JR., DELEGATE FROM ADAMS COUNTY

WHEREAS, The *Principles of Medical Ethics of the American Medical Association,* Section 8, requires physicians to obtain consultation in difficult cases or whenever it appears that the quality of medical service may be enhanced thereby, and

WHEREAS, Physicians consult with other physicians and not with industrial firms or laymen, and

WHEREAS, Many industrial firms and laymen are now attempting to practice medicine by way of displacing the physician who has specialized in pathology, and

WHEREAS, Both the American Medical Association and the Mississippi State Medical Association have repeatedly reaffirmed that the practice of pathology is the practice of medicine in an all relevant senses, and

WHEREAS, The *Journal of the American Medical Association* currently accepts advertisements of industrial concerns that solicit physicians to consult with them, and

WHEREAS, American physicians naturally trust the *Journal AMA* to provide the best in scientific and ethical standards, now, therefore, be it

Resolved, That the Mississippi State Medical Association express its belief that to replace physician-to-physician consultation with physician-to-industrial-firm consultation would be unwise and not in keeping with good medical practices, and be it further

Resolved, That this House of Delegates communicate its concern over such advertisements which appear in *Journal AMA* to the House of Delegates of the American Medical Association.

RESOLUTION NO. 4, IMPLEMENTATION OF PHYSICIAN-CORONER LAW, BY LEO J. SCANLON, DELEGATE FROM ADAMS COUNTY

WHEREAS, The Mississippi State Medical Association, at its 100th annual session, resolved that the county coroner should be a licensed doctor of medicine, and

WHEREAS, The Legislature and the Governor of the State of Mississippi have agreed with this principle and duly enacted House Bill No. 1110, The Physician-Coroner Act, into law July 18, 1968, and

WHEREAS, This law modernizes the office and increases its importance to the people of Mississippi, and

WHEREAS, Physicians are generally unfamiliar with the duties and privileges of this important county office, and

WHEREAS, Few physicians know how or have time to effectively organize and administer the necessary county level political campaign, now, therefore, be it

Resolved, That the Mississippi Medical Political Action Committee be requested to prepare educational material concerning the coronership and supply physician candidates with suitable material, coordination and expertise, and be it further

Resolved, That the Mississippi Medical Political Action Committee study the counties of Mississippi with the objectives of locating, encouraging and helping physician-coroner candidates, on a non-partisan basis, and be it further

Resolved, That the actions of the Mississippi Medical Political Action Committee first be approved and coordinated by the President and Board of Trustees of the Mississippi State Medical Association.

Dr. Scanlon Is Essayist at Homicide Institute

Dr. Leo J. Scanlon, Jr., of Natchez appeared as principal speaker during an institute on homicide conducted in March at the Jones County Junior College. Roy Moore of Jackson, special agent in charge of the capital's FBI office, headed the institute.

Dr. Scanlon conducted a seminar on forensic pathology for the conferees who consisted of selected Mississippi law enforcement officers. He stressed the medical aspects of crime detection from the viewpoint of the pathologist.

Baptist Hospital Names Staff Officers, Trustees

The state's largest nongovernmental medical institution, the Mississippi Baptist Hospital at Jackson, has named both a new group of medical staff officers and a Board of Trustees. State Medical association spokesmen noted with satisfaction that a physician has been elected a voting member of the governing board.

Four Jackson physicians head the medical staff for 1969-70. They are Drs. James M. Packer, president; Albert L. Meena, vice president; William S. Cook, secretary; and Noel C. Womack, Jr., president-elect.

Five additional Jackson physicians head services at the Baptist. They are Drs. Jim G. Hendrick, pediatrics; Blanche Lockard, ob-gyn; McWillie Robinson, surgery; T. E. Stevens, medicine; and Hardy B. Woodbridge, general practice.

Named to the hospital's governing board was Dr. G. Swink Hicks of Natchez, a past president of the Mississippi State Medical Association. He is currently a delegate to AMA from Mississippi, a member of the State Board of Health, and a director of Blue Cross-Blue Shield, the Mississippi Hospital and Medical Service.

Jackson attorney T. Harvey Hedgepeth was elected president of the Board of Trustees, succeeding Zack Hederman of Jackson. Each has 20 years service on the institution's governing body.

The state medical association expressed gratification at Dr. Hicks' election to the board. The association has a policy urging that physicians serve on governing boards of hospitals in a voting capacity.

PMA Issues Rx Drug Pamphlet

"The Medicines Your Doctor Prescribes" is the title of a new 8 page letter-sized booklet published by the Pharmaceutical Manufacturers Association.

Intended for wide distribution among consumers of prescription drug products, the booklet discusses the relationship of the doctor, the pharmacist and the patient in prescription drug use. It points out that such drugs actually are "medical treatment in product form."

The pamphlet foreword explains that "doctors know that different formulations of the same active drug ingredient often are available. The physician's medical judgment determines his choice among them. However, the pharmacist cannot know which specific product the doctor has selected nor will the doctor know in most cases which product the pharmacist dispenses, if only the generic name is given on the prescription. These are the reasons why more than 90 per cent of all prescriptions written specify either the drug's brand name or the name of the manufacturer."

The publication offers a number of practical tips to insure the safe and effective use of prescription drugs, and suggests that the consumers not only budget the cost of health as a literal "living" expense but also consider pre-payment insurance for prescription drugs.

NASA Offers Book on Bioinstrumentation

A new publication of the National Aeronautics and Space Administration describes advances in bioinstrumentation devices and techniques achieved by NASA.

Titled "NASA Contributions to Bioinstrumentation Systems," the major aim of the report is to facilitate use of these contributions in medicine and the bioinstrumentation industry.

Bioinstrumentation has been the fundamental tool used by NASA to learn about the medical problems of space flight.

Objectives of the report are to stress the correspondence between space flight and nonaerospace applications and to lay the groundwork for further projections of NASA's experiences.

It is available at $1 per copy as NASA SP-5054 from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

AAOS Sets PG Meet at Atlanta

The American Academy of Orthopaedic Surgeons will sponsor a postgraduate course on trauma and disease of the upper extremity May 15-17 in Atlanta, Georgia.

Directing the three-day course of lectures and panel discussions for the Academy's Committee on Injuries will be Dr. Wood W. Lovell, chief of the department of orthopaedic surgery at Georgia Baptist Hospital and surgeon-in-chief of the Scottish Rite Hospital for Crippled Children at Decatur.

The course for orthopaedic surgeons, general practitioners, general surgeons, and residents will be held at the Marriott Motor Hotel, Atlanta, in cooperation with Georgia Baptist Hospital.

Each of the three days will be devoted to a single area, opening with the shoulder and upper arm, followed by a day on the elbow and forearm, and the closing day on the hand.

Faculty members include orthopaedists from eleven states and Canada.

For application forms and further information, contact Dr. Wood W. Lovell, 340 Boulevard, N.E., Atlanta, Ga. 30312, or the American Academy of Orthopaedic Surgeons, 430 North Michigan Avenue, Chicago, Ill. 60611.

Dr. Grenfell Is Adviser to Medical Assistants

Dr. Raymond F. Grenfell of Jackson was recently elected to serve a three year term as physician adviser to the Central Mississippi Chapter of the Mississippi Association of Medical Assistants.

Other advisers currently serving are Drs. Maxwell D. Berman, Albert L. Meena, Walter H. Simmons, and E. Leonard Posey, all of Jackson.

Dr. Grenfell has served as chairman, Hinds County Heart Council; chairman, Professional Education Committee, secretary, vice-president, and president, Mississippi Heart Association; associate councilor, councilor, and chairman, Section on Medicine, Southern Medical Association; president, Mississippi Society of Internal Medicine; vice-president and member of council, American Therapeutic Society; president, Jackson Symphony Orchestra Association; president, and chairman, Medical and Dental Affairs Committee, Chamber of Commerce.

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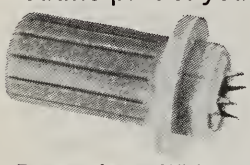
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Manuscripts should be typewritten, double spaced on one side of the paper. Tables, charts, and tabulations should be submitted on separate sheets but their position in the text should be indicated. Authors are encouraged to limit bibliographies to 10 references, written in conformation to style utilized in scientific publications of the American Medical Association. Articles are accepted for publication on the condition that they have not been previously published and are contributed solely to this JOURNAL.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text. Figures and drawings are acceptable when prepared with black ink on white paper. Photographs for illustrations should be unmounted, untrimmed, glossy prints and all such material must be identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Reprints may be obtained at cost from the association. The right is reserved to decline any manuscript for publication. Ordinarily, manuscripts submitted will be acknowledged whether published or not.

Index to Advertisers

Blue Cross 175
Bristol Laboratories 11
Burroughs-Wellcome 140D

Geigy Pharmaceuticals 8, 9, 10
Glenbrook Laboratories 176B

Highland Hospital 16
Hill Crest Hospital 19
Hynson, Westcott, and Dunning 3

Kay Surgical 7

Lederle Laboratories 4, 7, 14, 16, 20, 184A, 184B
Eli Lilly front cover, 18A, 18B

Mid-South Medical Association 2

Parke, Davis and Co. 14A
Pitman-Moore 14D, 15
William P. Poythress 6

Riker Laboratories 17, 18
A. H. Robins Co. 140A, 160A, 160B, 173
Roche Laboratories 140D, 170, 171, back cover

Sandoz Pharmaceuticals 176A
G. D. Searle 150B, 150C
Strasenburgh Laboratories 150D
Stuart Co. 181

Wallace Pharmaceuticals 178, 179
Warner-Chilcott Laboratories 168A, 168B
Winthrop Laboratories 150A
Wyeth Laboratories 14B, 14C, 21

Thomas Yates and Co. 12, 13

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CONTENTS

ORIGINAL PAPERS

Gram-Negative Septicemia and Endotoxin Shock: A Rationale of Management **191** W. L. Weems, M.D., and J. E. Aldridge, M.D.

Tuberculous Meningitis: A Study of General Hospital Patients in Mississippi **196** John Ricks, M.D., and Fred Allison, Jr., M.D.

Importance of Technique in Roentgen Examination of the Small Intestine **201** Charles M. Nice, Jr., M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXIV **207** James B. Barlow, M.D.

EDITORIALS

Blue Cross Chief Makes Strong Medicine **211** More Muscle for Cross

Sock It to Me: 100 Decibels Plus **212** Rock and Deaf

In the Shoes of Government **212** Part 1-B in Court

Count the Calories— and the Cyclamates **213** Question on Sweeteners

THIS MONTH

The President Speaking **210** Carrying the Tasks Forward

Medical Organization **219** Gift to Library

Meetings **209** Society Circuit

Officers **234** Full Listing

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HIAA Calls for Care Reorganization

The reorganization of present methods of hospital care and treatment of patients was called for in a panel discussion at the 1969 Group Insurance Forum sponsored by the Health Insurance Association of America at Philadelphia.

One of the more effective ways the health insurance business can help in this regard is to become more involved in planning activities, said Jerome Pollack, associate dean for medical care planning at Harvard Medical School.

"We are greatly in arrears in planning," he told the Forum. "Bold planning is imperative. We must start to do something about it."

Pollack said it is too expensive for the average hospital—which has an occupancy rate of 76 per cent—to have one fifth of its beds vacant.

Other panel members were Lawrence E. Martin, associate director and comptroller of the Massachusetts General Hospital; and Dr. George Dunlop, a surgeon from Worcester, Mass.

The satellite concept is becoming established as cases are being sent from surrounding community hospitals to a centrally located hospital involved with acute, more expensive cases, Martin said.

"Hospitals no longer can generate income through ancillary charges," he said. "Income must come from the room and board charges."

"Planning is going in the wrong direction," Martin noted, "Although we have concentrated on stopping duplication of services, I would be more comfortable if they devised a new concept of distribution of care."

Hospital outpatient clinics must provide low cost ambulatory care—something they have not been able to do as traditionally defined, according to Dr. Dunlop.

These clinics—many of them new, but with outdated treatment methods—have not been the result of sound planning, he said.

Dr. Dunlop cited the need for hospitals to "compete" with each other in order to lower costs and improve treatment.

"We need to put competition into action," he said. "We have had very little competition in performance as related to costs."

He said physicians must keep up with medical advancements through the available facilities or the government will move in and possibly ask for their recertification.

Although the physician has long resisted the "team approach" as the answer to more effective medical care, Dr. Dunlop said the physician knows

the difficulties in one person carrying out all the procedures and now realize this approach is needed.

He questioned whether group practice—the closed panel type when MDs are salaried—has the wide applicability as has been suggested.

The patient looks at medical care as high quality and guaranteed; the physician looks at the time, effort and remuneration, he said, and the patient may not always be aware of this difference.

Dr. Dunlop said it will have to be shown whether high quality care can be delivered under closed panel group practice and whether the public will accept it.

Dean Rusk to Address AMA Meet

Former Secretary of the State Dean Rusk will be among the widely-known authorities participating in the American Medical Association's Fourth Conference on International Health.

The conference will be May 22 and 23 at the LaSalle Hotel in Chicago. Its theme is "U. S. Efforts in International Health Today and Tomorrow."

Conferees will review present endeavors in international health by groups and individuals from the United States. Those participating will attempt to delineate more clearly how American medicine can establish and support an increasingly meaningful role in this area.

Rusk, now a Distinguished Fellow of the Rockefeller Foundation (where he was President before becoming Secretary of State in 1961), will address the May 22 luncheon. Others of national and international reputation also will speak during the two-day conference.

General subject areas include:

—The role of research and development in international health

—Delivery of health services in the international field

—Significance of manpower development in international health

Fireside workshops Thursday evening, May 22, will consider international medical education, activities of church-related groups abroad, sponsorship of volunteer physicians overseas (including the AMA's program in Vietnam), and collection and distribution of medical supplies.

The program is open to representatives of companies, institutions, government agencies, and individuals with an interest in international health.

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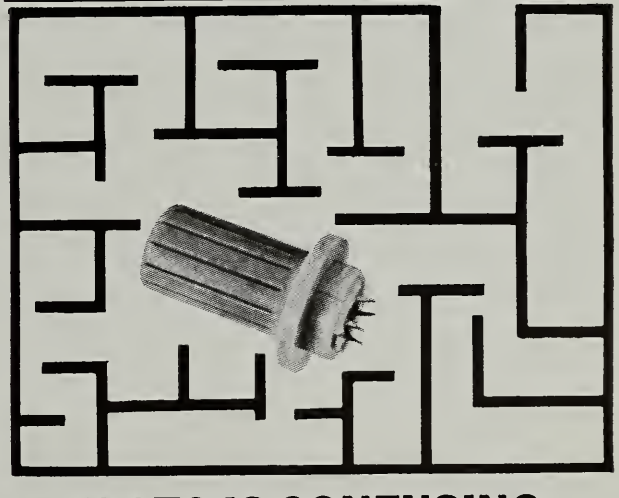


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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION

JACKSON, MISSISSIPPI

May 1969

Dear Doctor:

Under Secretary of HEW John G. Veneman says that Medicaid payments to physicians will not exceed local Blue Shield schedules. Move is described as economy measure of Nixon administration for zooming Title XIX costs. Most observers see action as arbitrary because of widely varying Blue Shield schedules.

> AMA President Wilbur has filed protest with HEW, at same time offering AMA's services in cost problem. National Blue Shield President John W. Castellucci says he was not consulted on HEW action.

Three of Mississippi's four charity hospitals have had federal funds cut off for alleged violation of Civil Rights Act of 1964. Decree is effective May 7 for hospitals at Meridian, Natchez, and Vicksburg. The Laurel institution is not mentioned. State officials say that effect will be minimal because of low, token funding.

The California Relative Value Index, most popular basis for usual and customary fees, will be drastically changed in July. California Medical Association has announced new version which will have five-digit procedure codes and new system of unit values. New edition will be available from California Medical Association.

The Food and Drug Administration will feel the Nixon economy ax with elimination of 298 jobs set up in the Johnson budget. Money cut applies to Consumer Protection and Environmental Health Services of which FDA is a part, so specifics as to where ax will fall are not yet determined. Chances are that iron-fist control over drugs will not be affected.

And as a postscript to medical care costs, try getting a pipe or faucet fixed in Philadelphia or San Francisco. Plumbers union in Philadelphia negotiated wage rates last month of $9.60 per hour, while the scale fixed in Golden Gate City is $10.60 per hour. This means that union plumbers will earn $25,000 per year without overtime.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

PMA Scores Esquire Blast At Drug Makers

Washington - Esquire Magazine, once the final word for men's fashion and curvy Petty girls, was the target for Pharmaceutical Manufacturers Association over a March article on drugs. PMA President C. Joseph Stetler called the article, which muckraked industry, "shallow, supercilious, misshapen commentary" of the anti-Establishment crowd. Esquire, now gone hippy, carried the story over by-line of former FDA Commissioner James L. Goddard. Story portrayed drug industry as greedy monopoly and physicians as stupid dupes of slick detail men.

ACS Produces TV Films On Tetanus

Chicago - The American College of Surgeons has produced four TV spot films in color on tetanus prophylaxis for release to 200 TV stations soon. Educational project alerts general public to danger of tetanus by underscoring need for immunization and care of even minor wounds. Each film runs one minute.

NIH Raises Questions On Artificial Heart

Bethesda, Md. - Spokesmen for the National Heart Institute of NIH have asked Dr. Michael DeBakey if any federal funds were involved in development of artificial heart implanted by Dr. Denton A. Cooley in patient Haskell Karp last month. The Texans said that prosthesis was developed with Texas money, but DeBakey and Cooley have received huge sums in federal grants for research. Claim was made by NIH that experiments must follow guides where federal money is used. Inference is that guides were not followed.

Cigarette Advertising Issue Nears Climax

Washington - Congress has a hot potato or, more properly, a hot cigarette on its hands. The advertising labèling act expires July 1 and with it goes prohibition against federal interference in advertising. FCC says it will ban fag advertising from TV and radio if law expires. Tobacco states congressmen are working feverishly to halt ban. Chances are that tougher warning will be placed on fag packs and advertising limited to small extent.

Medical Constructions Booms, Increases Employment

New York - The Health Insurance Institute reports that the boom in hospital and medical construction has increased employment among builders by 13,000 new jobs in 1969. Interesting note is that health insurance companies, usually strong in life coverage, made most of the construction loans.

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The Disease Detection Information Bureau, marking its first anniversary, is now aiding diabetes detection programs in 14 states throughout the nation.

DDib, a public service organization supported by the Ames Company of Elkhart, Indiana, was organized one year ago to serve as a source for informational and educational materials in a number of different disease conditions which can be readily detected through medically approved screening programs.

Its initial task is to serve as national headquarters for "Why Wait?" diabetes detection programs. Such programs have been initiated in the following states: Alabama, California, Delaware, Florida, Georgia, Hawaii, Illinois, Kansas, Missouri, New York, Oklahoma, South Carolina, Tennessee and Texas.

DDib provides aid to any community in the country which is interested in conducting a diabetes detection program and which follows an established protocol, including use of blood rather than urine testing procedures, medically approved and supervised testing, referral of positive screenees to their own physicians and maintenance of adequate records and statistics.

This aid includes provision of a "how-to-do-it" campaign manual and a kit which contains a wide variety of field-tested promotional materials. Bulk quantities of certain promotional materials such as folders, posters, and bumper stickers are provided by DDib, free of charge, to communities conducting "Why Wait?" diabetes detection programs.

DDib places major emphasis in motivating communities to conduct ongoing diabetes screening programs for high risk groups, since experience has shown that such programs are most producting of finding undetected diabetics.

However, DDib also supports shorter term programs.

For communities conducting, or interested in conducting, diabetes screening programs, DDib produces a monthly Disease Detection Newsletter which channels to them information on results, practical problems and solutions, and other pertinent data from all other detection programs throughout the U. S.

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DUO-MEDIHALER®

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Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
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Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

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NCI Cites Research Progress

The National Advisory Cancer Council believes that rapid new gains against cancer through the sophisticated approaches of modern biomedical science will require a nationwide network of centers combining research, medical education, and patient care.

The Council's view is given in "Progress Against Cancer 1969," its third report to the public on the status and outlook of research and related efforts to control cancer through prevention, diagnosis, and treatment. The body of scientists and medical experts is advisory to the Director of the National Institutes of Health on policies and programs for support of research and training administered by the National Cancer Institute.

Continued improvement in the outlook for cancer patients has come mainly from advances in a few institutions staffed and equipped to integrate research and medical management, the 83-page illustrated report states. Less than two dozen institutions, situated mainly in the northeast, approach the cancer center ideal, the report explains. "Others need to be provided and so distributed throughout the country that the advancements attained in the medical management of malignant diseases will become available to people everywhere as rapidly as possible," it states.

"Progress Against Cancer 1969" is devoted mainly to a review of progress in drug treatment. It reports that advances have been most encouraging in chemotherapy of leukemia with consequent lengthening of patient survival from one year to three years over the past four years. Suggesting that this trend may in time justify acknowledged cure of some leukemia cases, the report cites a conclusion from worldwide studies by the National Cancer Institute's Acute Leukemia Task Force that discontinuance of therapy appears justifiable "and perhaps advisable" seven years after diagnosis if a patient has had no evidence of disease for at least four years.

Treatment with combinations of drugs is credited with the principal gains against leukemia. A regimen of four-drug treatment has also been most effective against far-advanced Hodgkin's disease, early or localized cases of which respond well to intensive radiation. Less success has been achieved in drug treatment of the slower growing "solid" tumors than with cancer of the blood and lymphatic system such as leukemia and Hodgkin's disease, the report states.

"Progress Against Cancer 1969" can be purchased from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. The price is $1.50 a copy.

PROGRESS REPORT: OPERATION UPGRADE

GROUP MEMBERS

MARCH 1967 THROUGH JANUARY 1969

BENEFIT PATTERN	MARCH 1967	JANUARY 1969	CHANGE	%
4TH DAY MEDICAL OR LESS	239,717	146,692	− 93,025	− 39%
1ST DAY MEDICAL $3	16,594	44,797	+ 28,203	+170%
1ST DAY MEDICAL $4	10,260	17,528	+ 7,268	+ 71%
1ST DAY MEDICAL $5 OR BETTER	51,672	118,572	+ 66,900	+129%
TOTAL WITH 1ST DAY MEDICAL	78,526	180,597	+102,071	+130%
TOTAL GROUP ENROLLMENT	318,243	327,589	+ 9,346	+ 2.9%
PERCENTAGE OF GROUP ENROLLMENT WITH 1ST DAY MEDICAL	24.67%	55.13%	30.46%	

BENEFIT PATTERN	MARCH 1967	JANUARY 1969	CHANGE	%
SURGICAL $200 OR LESS	233,851	158,927	− 74,924	− 32%
SURGICAL $225	2,230	20,430	+ 18,200	+816%
SURGICAL $300 OR BETTER	82,162	148,232	+ 66,070	+ 80%
TOTAL WITH $225 OR BETTER	84,392	168,662	+ 84,270	+100%
PERCENTAGE OF GROUP ENROLLMENT WITH $225 OR BETTER	26.51%	51.49%	24.98%	

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Ob-Gyn Seminar Is Set for Asheville

The 15th Annual Southern Obstetric and Gynecologic Seminar has been announced for July 28-Aug. 1 at the Grove Park Inn, Asheville, N. C., according to Dr. George T. Schneider of the Ochsner Clinic, New Orleans.

Dr. Schneider said that "a wide variety of ob-gyn subjects would be covered, including a comprehensive review of gynecologic pathology by Dr. Carl Dougherty of the LSU School of Medicine."

The seminar is designed for informal teaching during the Monday through Friday schedule, offering morning sessions with afternoons free for recreation and family entertainment. The program format also includes open discussion sessions and panel presentations.

Faculty for the seminar will be made up of Drs. F. Bayard Carter and Ahristakos of Duke University, Robert Ross who is president-elect of the American College of Obstetrics and Gynecology, and Cary Dougherty, Abe Mickal, and George T. Schneider of LSU.

Also serving as faculty will be Drs. Robert Franklin, Raymond Kaufman, and Herman Gardner of Baylor University, Erskine Carmichael of the University of Alabama, Robert Greenblatt of Georgia, Stewart Fish of the University of Tennessee, and Charles Hendricks of the University of North Carolina.

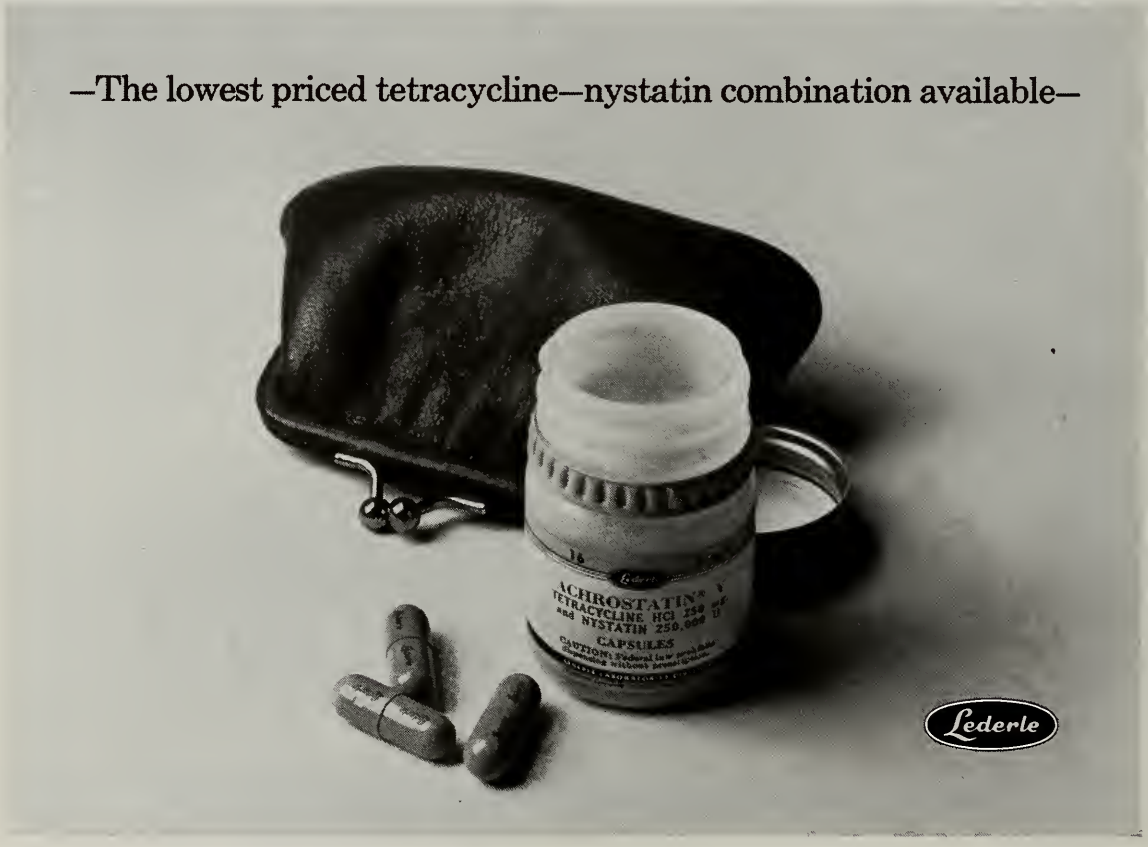
Registration will be limited to the first 50 applicants, and the $50 fee includes a social occasion and banquet at mid-week. Application may be made to Dr. Schneider at the Ochsner Clinic, 1514 Jefferson Highway, New Orleans 70121.

UMC Will Confer 76 M.D. Degrees

The University of Mississippi Medical Center will hold its 13th Annual Commencement June 8 at 4 p.m. in the Jackson Municipal Auditorium with Dr. Leon O. Jacobson, Dean of the Division of Biological Sciences, The University of Chicago School of Medicine, as speaker.

Chancellor Porter Fortune will confer degrees upon graduates of the School of Medicine, the School of Nursing, and graduate studies in the health sciences. Candidates for the M.D. degree total 76.

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ORIGINAL PAPERS

Gram-Negative Septicemia and Endotoxin Shock: A Rationale of Management

W. L. WEEMS, M.D., and J. E. ALDRIDGE, M.D.
Jackson, Mississippi

Forty-four patients have been treated for gram-negative septicemia on the Urology Service in the past three years. The authors discuss the plan of management adopted by the service and review the pathophysiology of endotoxin shock.

Septic shock is one of the commonest causes of mortality in hospitalized patients and gram-negative organisms play the leading role.[1] General awareness of this problem has led to a prodigious amount of research and a voluminous literature on this subject. Emphasis has been on the role of endotoxin. Great progress has been made in understanding the pathophysiology of this complex syndrome, but much remains to be learned, as evidenced by failure of available knowledge to produce a generally accepted approach to clinical management of the problem. With incomplete knowledge and controversy accepted as inescapable facts, the clinician must formulate for himself a plan of management of a common disease which carries a reported mortality risk approaching 50 per cent. It is the purpose of this paper to briefly review the pertinent information concerning the pathophysiology of endotoxin shock and to outline the plan of management that has been adopted by the Urology Service at the University of Mississippi Medical Center.

Forty-four patients have been treated for gram-negative septicemia on the Urology Service in the past three years. Twenty-three were hypotensive at some time during the acute septic episode. Six fatalities have occurred for a mortality rate of 14 per cent. Of these, five had severe underlying disease. One patient underwent anterior pelvic exenteration, right nephroureterectomy and ureterosigmoidostomy for advanced carcinoma of the bladder. She became uremic and septic postoperatively. An 88-year-old male had had a recent myocardial infarction before succumbing to sepsis as a complication of carcinoma of the prostate. A 71-year-old male with severe emphysema died of septicemia and pneumonia, following transurethral resection of the prostate. A 71-year-old man was comatose as a result of a cerebral vascular accident following transurethral resection. Septicemia was diagnosed postmortem and had not been treated. A 76-year-old male was uremic

From the Department of Surgery, University of Mississippi School of Medicine.

as a result of carcinoma of the prostate with extensive metastases before his demise with sepsis.

Our overall mortality rate of 14 per cent was lower than that reported by most writers, and experience has shown that associated problems play an important role in mortality, a fact which must be considered in evaluating therapy. The ideal clinical model for testing the effectiveness of a therapeutic program for endotoxin shock is the patient who has septic shock as an isolated entity. In this type patient, our results have been remarkably good and reinforce our belief that the following rationale of therapy is sound.

Common sources of confusion in the literature should first be clarified. Shock is frequently discussed without clear distinction of its etiology. It may be of hypovolemic, cardiogenic, anaphylactic or septic origin. The rationale of lumping these together when "reversible" and "irreversible" shock are discussed is that all share a final common pathway; i.e., disturbance in microcirculation and tissue hypoxia. Another unifying factor is the theory that elaboration of endotoxin by intestinal organisms may contribute to irreversibility in the terminal phase of all forms of shock.[2] However, this event is not an essential feature of irreversible shock, since the typical progression to irreversibility in hemorrhagic shock has been demonstrated in germ free animals.[3]

CONFUSION IN DEFINITION

Another source of confusion is the poor definition between septic shock and endotoxin shock. Endotoxin is presumed to be the factor responsible for the shock syndrome due to gram-negative infection. The mechanism of action of endotoxin elaborated by the various organisms is thought to be the same qualitatively with quantitative differences in potency. Endotoxin shock may occur from localized infection without blood stream invasion but this is probably rare. The overwhelming presence of living organisms in the circulation may have deleterious effects aside from the effects of endotoxin. It is certainly true, in the clinical situation, that the disease process causing bacteremia (strangulation obstruction of gut and peritonitis) often is associated with significant shifts in body fluids. While provision must be made in patient management for these complicating factors, the remainder of this discussion of septic shock management will be predicated on the basis of the pharmacologic action of endotoxin.

Endotoxin is a lipopolysaccharide contained in the cell wall of gram-negative bacteria. Its toxic effects may be many. Myocardial toxicity has been reported, but the cardiogenic role in shock probably is not great. There is central nervous system toxicity which may be responsible for confusion and agitation. The adrenal is stimulated to increased production of epinephrine, norepinephrine and cortical steroids. There may be a general undefined toxic effect on parenchymal cells of the various organs, but this has no proven role in the shock syndrome. There are changes in the coagulation mechanism with intravascular clotting and depletion of fibrinogen.[4] These are but a few of the changes ascribed to toxicity of endotoxin. In many instances it is difficult to determine whether these effects are due to direct toxicity or due to cellular and organ dysfunction secondary to anoxia.

ENDOTOXIN EFFECT

The central feature of endotoxin toxicity, and perhaps the only essential in the production of septic shock, is its intense sympathomimetic effect on the microcirculation.[3] Endotoxin itself is not vasoactive. It combines with some formed element in blood, probably the leukocyte, to produce potent sympathomimetic substances. In addition, the adrenal is stimulated to increase epinephrine and norepinephrine production.

A brief consideration of an idealized capillary network and of the concept of alpha and beta adrenergic receptors is essential to an understanding of the sequence of events in endotoxin shock and of the rationale of therapy.[5] Alpha and beta receptors have not been defined anatomically. Their existence is postulated on the basis of observed responses to adrenergic drugs. Alpha activity is associated with an excitatory effect of vasoconstriction and an inhibitory effect on the smooth muscle of the gut. Beta activity is associated with the inhibitory effect of vasodilation and an excitatory effect of myocardial stimulation. On both the arterial and venous sides of the capillary network are smooth muscle sphincters which are responsive to adrenergic stimulation. Alpha stimulation causes constriction of these sphincters. This raises peripheral resistance and increases arterial pressure. Continued constriction, however, on the venous outflow side, causes pooling in the capillary bed, decrease in venous return and a reduction in cardiac output. The net effect of vasoconstriction may therefore be a drop in blood pressure and a narrowing of the pulse pressure.

There is evidence that the vasoconstriction on

the arterial side gives way under the influence of anoxia and acidosis due to anaerobic metabolism before the venous constriction. This further aggravates stasis and pooling in the capillary bed. Under these conditions of anoxia due to stasis and increased capillary pressure, there is loss of fluid into the interstitial space. This increases the venous hematocrit and further reduces venous return. Cellular anoxia and anaerobic metabolism begin to take a toll.[6] At this point, shock enters the stage of irreversibility. Beta stimulation causes dilation of these vascular sphincters. Decrease in peripheral resistance results. Arterial pressure is lowered. This effect is compensated by an increase in venous return as the "flood gates" on the venous side of the capillaries are opened. Cardiac output is increased, the myocardium is stimulated, and the pulse pressure widens.

ADRENERGIC AGENTS

There are many drugs with adrenergic activity, and only a few examples can be given here.[7] Methoxamine (Vasoxyl) has a pure alpha adrenergic effect. Arterial pressures are increased and venous return is decreased. Isoproterenal (Isuprel) is a potent betamimetic drug. Aortic pressure is reduced, venous return is increased and pulse rate increases. Epinephrine is an example of drugs with both alpha and beta effects with variable predominence of one or the other. Phentolamine (Regitine) and phenoxybenzamine (Dibenzyline) produce an alpha adrenergic blockade.

This idealized description of microcirculatory response to adrenergic influences is complicated by the fact that the response of capillary beds varies in different organ systems. For instance, the splanchnic and renal vasculature are much more profoundly influenced by alpha stimulation than are those of the brain and skeletal muscles.[8] A fact that has undermined the credibility of laboratory research in shock is that "target organs" of adrenergic stimulation vary in different experimental animals. This factor, as much as any other, has retarded the application of knowledge gained in the laboratory to the management of shock in humans. This problem remains, but it is increasingly being accepted that, while specific manifestations differ in different animal species, the net effect on the organism is very similar.[3]

Endotoxin induces intense alpha adrenergic stimulation. This leads to serious derangement of splanchnic, renal, and probably pulmonary circulation and the sequence of events described for alpha stimulation is set in motion. If this concept is accepted, rational therapy must be designed to overcome this alpha adrenergic effect and not simply to increase arterial pressure by further alpha stimulation. The problem is not merely that of decreased blood pressure, but more a problem of diminished venous return and poor tissue perfusion. It is obvious that the earlier in the chain of events that therapy is instituted, the greater the chance of success. Ideally, endotoxin shock should be prevented by vigorous treatment of infection before a toxic "dose" of endotoxin is elaborated. If shock is allowed to progress to the point of destruction of the integrity of capillary vessels and of the viability of parenchymal cells, all therapy will be futile. Between these two extremes are patients who may be salvaged by vigorous and appropriate therapy but who would otherwise surely die. With this background, let us briefly and arbitrarily discuss the modalities of therapy that we employ.

A high index of suspicion is essential for diagnosis, and high risk situations should be recognized. Most patients have spiking fever and chills, but occasionally, especially in older individuals, fever may be minimal or absent. Unexplained hypotension, oliguria, mental confusion, air hunger, and poor peripheral perfusion should be viewed with suspicion. Blood cultures should be obtained in any questionable situation. Hypovolemia, myocardial infarction, and pulmonary embolism should be considered in the differential.

EARLY ANTIBIOTIC THERAPY

The presence of viable organisms in the systemic circulation must be immediately abolished. Vigorous and early antibiotic therapy is essential. The choice of drugs is controversial. Frequently the identity of the organism and its antibiotic sensitivity are unknown. "Shotgun" therapy is clearly justified. The physician who insists on identifying the organism and then treating it specifically endangers the life of his patient. The choice of drugs perhaps should vary with the environment. The patient who becomes infected at home is likely to respond to any broad spectrum antibiotic. The patient who is infected with a hospital organism is more likely to harbour a resistant strain. In our hospital enviroment, we frequently combine kanamycin, colistin and cephaloridine or ampicillin. When the offending organism is identified, the "shotgun" approach is discontinued and the infection treated specifically.

Surgical treatment of infection must not be overlooked. Abscesses must be drained, necrotic

tissue debrided, and urinary obstructions must be relieved.

Preexisting blood volume deficits should be corrected by transfusions of whole blood. Significant shifts of fluid occur into interstitial tissues. This fluid is a transudate until very late in the shock syndrome, when frank bleeding into the interstitium may occur from loss of capillary integrity. This sequestered fluid is appropriately replaced with a balanced electrolyte solution such as Ringer's lactate. Correction of metabolic acidosis by alkali therapy or buffers has been advocated by some writers, but probably is not essential and may be hazardous. The amount of fluid replacement is the critical question. Large volumes, on the order of 6 to 8 liters in 24 hours, are sometimes required, depending on the stage of development of the shock syndrome. The rate of administration and the volume of fluids given must be individualized. The patient's response in terms of improvement of blood pressure and increased urine output should be carefully monitored. Serious overload during rapid fluid administration may be avoided by frequent measurement of the central venous pressure.

QUESTIONABLE THERAPY

The value of glucocorticoids in the therapy of endotoxin shock is controversial. There is no evidence that adrenal insufficiency contributes to the shock syndrome since blood levels of cortical steroids are increased by endotoxin. Furthermore, the salutary effect of glucocorticoid therapy observed experimentally and clinically is not from physiologic doses; but from pharmacologic doses of 10 to 20 times the usual replacement amount. There is suggestion that, at this high dosage, there is an alpha adrenergic blocking effect.[3] Also suggested is the possibility that cellular integrity is protected by high blood levels of glucocorticoids under conditions of anoxia and acidosis.

At any rate, there is evidence of a beneficial effect on survival and little evidence of any deleterious effect of the short-term use of these drugs. If the patient is severely ill when the diagnosis of septic shock is made, or if there is not prompt response to antibiotics and fluids, we institute steroid therapy. We have used methylprednisolone sodium succinate (Solu-Medrol), but have no reason to think that other parenteral glucocorticoids would not be as effective. Solu-Medrol, 125 mg., is given rapidly intravenously; then 125 mg. IV q 4 to 6 hours is given for the duration of the shock syndrome. The drug is then discontinued, usually after 24 to 36 hours, without gradual withdrawal.

BETA STIMULATOR

There is increase in peripheral resistance and decrease in venous return in endotoxin shock. Since this alpha adrenergic effect seems to play an important role in the pathogenesis of irreversible shock, further alpha stimulation with drugs such as Vasoxyl, Levophed, and Neo-Synephrine seems contraindicated. There is considerable experimental evidence to support the concept that improved tissue perfusion and increased venous return are best accomplished by alpha adrenergic blockade or by beta adrenergic stimulation. Lillihei advocated alpha blockade with Dibenzyline.[3] We have no experience with this drug, and it has not been released by the Federal Drug Administration for general use. We have, instead, employed the beta adrenergic stimulator, isoproterenol (Isuprel).

The drug is administered "piggy-back" into intravenous infusions as a solution of 1 mg. per 500 cc. of D5W at the rate of about 1 to 2 cc. per minute. Favorable response is manifested by an increase in blood pressure from shock level, improvement in peripheral perfusion, and increase in urine output. Urine output is the most sensitive objective measure of beneficial effect. The oliguria of endotoxin shock is, to a large extent, due to intense vasospasm in response to alpha adrenergic stimulation. If increased renal blood flow, and as a result, increased urine output, can be accomplished by alpha adrenergic blockage or beta adrenergic stimulation, improvement in perfusion of other important vascular beds can be presumed. Because of myocardial stimulation by Isuprel, pulse rate is increased. The drug should be used cautiously if pulse rate is greater than 100. Myocardial stimulation may play a minor role in increasing cardiac output. Improvement in venous return, however, is the most important factor in increasing cardiac output.

PROPHYLACTIC DIGITALIZATION

Rapid digitalization is indicated if there are signs of heart failure, but impaired cardiac function is not a cause of poor cardiac output in most patients. A margin of safety may be provided for the rapid administration of fluids by prophylactic digitalization. Lillihei has recommended digitalization of all patients over 50.[3]

Oxygen therapy may be helpful and has been used in all our patients in shock.

OUTLINE OF MANAGEMENT

A—When the diagnosis of septic shock is suspected, obtain the following studies:

1. Blood culture
2. CBC
3. BUN
4. Serum electrolytes
5. EKG
6. Chest x-ray

B—When there is acute sepsis without shock, therapy includes:

1. Intravenous fluids
2. Antibiotics
3. Temperature control measures

C—When there is sepsis with shock as manifested by hypotension and oliguria, the program includes:

1. Rapid administration of fluids
2. "Shotgun" antibiotics
3. Glucocorticoids
4. Oxygen
5. Digitalis in selected cases

D—When there is poor response of blood pressure and urine output, Isuprel infusion is added.

E—The clinical course must be carefully monitored so that therapy may be titrated:

1. Measure blood pressure and pulse q 15 minutes
2. Measure temperature rectally q 1 hour
3. Obtain venous pressure measurement q 1 hour
4. Measure hourly urine output.

SUMMARY

The pathophysiology of endotoxin shock has been discussed briefly. A therapeutic program has been outlined which seems rational on the basis of available knowledge. With this approach we have achieved a mortality rate of 14 per cent in 44 patients with gram-negative septicemia.

2500 North State St. (39216)

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LO, THE TAXPAYER!

J. G. Martin, Jr., of Jackson, district director of Internal Revenue, has gleaned a few gems from Mississippians' tax returns:

—One elderly woman, anxious to pay the minimum amount due, tried to take depreciation on her aging husband.

—Another taxpayer, citing civic duty, wanted to deduct a portion of his liquor bill. He said that in response to his mayor's plea to conserve water he had increased his booze consumption.

Tuberculous Meningitis: A Study Of General Hospital Patients in Mississippi

JOHN RICKS, M.D., and FRED ALLISON, JR., M.D.
Jackson, Mississippi

From July, 1955, through December, 1965, 54 patients with tuberculous meningitis were admitted to the University Medical Center. The authors present a retrospective analysis of the results of treatment in these patients. Altogether, 29 patients died, with the highest mortality being in patients under 5 years of age.

Disseminated tuberculosis recognized as meningitis represents a continuing diagnostic and therapeutic problem. Tuberculous meningitis usually develops after hematogenous spread from a pulmonary focus; the rate of occurrence, therefore, reflects directly the frequency of tuberculosis of the lung in the population. Recent reports indicate that tuberculous meningitis has been encountered less frequently than previously as the overall occurrence of new cases of pulmonary disease declines. Furthermore, mortality from meningitic tuberculosis has been reduced significantly by antimicrobial therapy so that 75 to 80 per cent of patients treated in large metropolitan centers survive.[1, 2]

We were interested to determine the experience with this disease in Mississippi since a substantial number of new cases of pulmonary tuberculosis have been found each year since our hospital opened.[3] This retrospective study covers all patients admitted to the University Medical Center from July, 1955, through December, 1965.

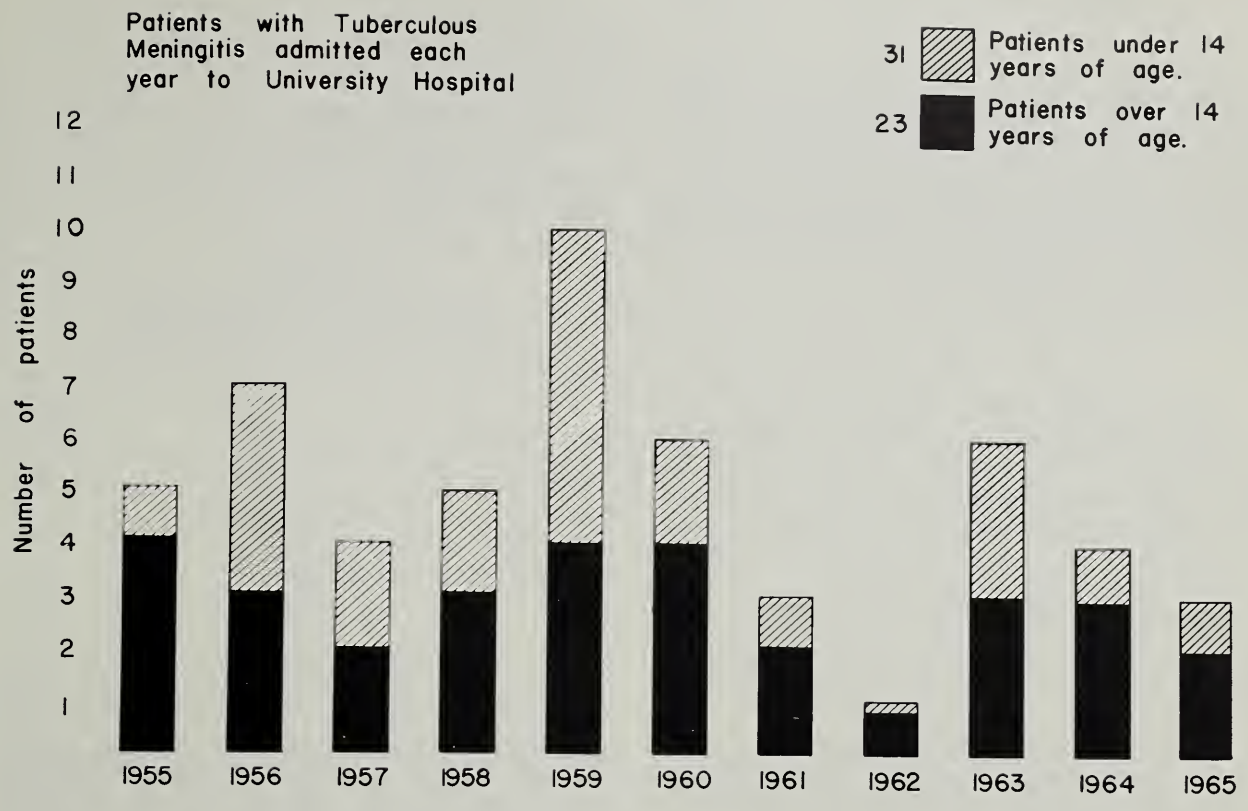
Altogether, 54 patients admitted to the pediatric and adult wards of the University Medical Center (UMC) were studied as may be seen in Table 1. This hospital serves as a general referral center for indigent patients from all portions of the state as well as for a small group of referred private patients. The hospital was open for only half of 1955 and it was not fully operational with all beds available until 1957. Even so, it is apparent that almost twice as many patients (32) with meningitis were recognized between 1956 and 1960 as were noted (17) in the next five years from 1961 through 1965. Patients were hospitalized from all sections of Mississippi although more originated locally from Hinds County, the most populous area of the state, than from any other single area. No effort was made to select patients since the gravity of their illness dictated hospitalization.

As may be seen in Table 2, 23 patients (43 per cent) were under 14 years of age even though beds available to this age group made up only about 15 per cent of the total in-patient capacity of the hospital. Another 11 patients (20 per cent) were over 50 years of age. In keeping with this distribution, mortality rates were highest for the extremes of age with the lowest rate found in the teen-age and the adult group between 20 and 50 years.

Of 22 patients under 5 years of age, 17 were female (Table 2). This was in contrast to the incidence in patients over 10 years of age where

From the Division of Infectious Diseases, Department of Medicine, University of Mississippi School of Medicine.

TABLE 1



there were 16 females and 15 males.

Black patients far exceeded whites with 48 Negroes and 6 Caucasians found. Likewise, 26 black patients died as compared to 3 whites (Table 2).

A total of 21 of the 54 patients had positive spinal fluid cultures for *M. tuberculosis* (Table 3). An additional 10 patients with meningitis had negative spinal fluid cultures, but tubercle bacilli were grown from sputum as well as from other sources. The diagnosis of tuberculosis meningitis was made on four other occasions only at postmortem examination. The diagnosis of tuberculous meningitis in the 19 remaining patients was made on clinical grounds alone. These criteria included the clinical findings of meningitis, increased spinal fluid pressure, elevated spinal fluid values for protein and lowered for glucose, and a modest pleocytosis predominantly mononuclear in character. In addition, a response to therapy with antituberculous drugs was interpreted as confirmatory evidence for this diagnosis.

Combined treatment with conventional amounts of three antimicrobials was employed in every patients. These were isonicotinic acid hydrazide (INH), para-aminosalicylic acid (PAS), and streptomycin. No unusual treatment programs were undertaken and intrathecal administration of drugs was not employed. Supportive administration of glucocorticosteroids was employed more frequently than not since a majority of the patients were gravely ill when hospitalized.

SURVIVAL RATE

Only 25 of the 54 patients survived (48 per cent) the acute phases of meningitis and all of these were alive when followed in 1968. Of the 54 patients, 22 died at the University Medical Center within three weeks after hospitalization. The remaining 32 patients were discharged and their clinical course can be summarized as follows (Table 4):

One psychotic patient discharged to the Mississippi State Hospital for the Mentally Ill was treated successfully and is alive with the infection apparently arrested.

Eight other patients were treated at the UMC until their improved condition permitted discharge for subsequent treatment at home. Two of these patients died shortly after they were sent home (Table 4), presumably of causes related to the disease. The remaining six are alive, but two of these are known to have serious neurologic sequelae.

The largest number of patients, 23, were transferred to the Mississippi State Sanatorium (MSS) for treatment by that facility. Four died at the MSS as a result of the tuberculous infection. One patient died after transfer to Mississippi State Hospital for the Mentally Ill, presumably also of tuberculosis. A sixth patient died of an unrelated disease (Table 4).

SEX-RACE DIVISION

The 54 patients can be broken down in yet another way (Table 2). Of the 48 Negro patients in the series, 26 died. Eighteen of 26 Negro deaths were female, and 12 of these were under age 5 years. Only 3 of 8 Negro males under the age of 5 years died, whereas, 5 of 10 Negro males of adult age died. Fourteen of 25 living patients were female. Only 7 of 25 living patients were under 5 years of age, another living patient was between the age of 6 and 10 years and 15 others were over the age of 11.

None of the 6 white patients with tuberculosis were of pediatric age, although one patient was in the age group of 11 to 20 (Table 2).

For the 25 survivors, it was found that the mean duration of symptoms prior to start of therapy was approximately 38 weeks. The duration of symptoms was slightly less, i.e. 37 weeks, for the 27 patients that died. The small difference probably was not significant since an exact documentation of the onset of symptoms was difficult to establish.

TABLE 2

RESULTS OF TREATMENT OF TUBERCULOSIS MENINGITIS BY AGE, RACE, SEX UNIVERSITY MEDICAL CENTER, 1955-1965

	Living				*Dead*			
	WHITE		BLACK		WHITE		BLACK	
Age Groups	Male	Female	Male	Female	Male	Female	Male	Female
0 to 5 yrs.	0	0	2	5	0	0	3	12
6 to 10 yrs.	0	0	1	0	0	0	0	0
11 to 20 yrs.	1	0	2	1	0	0	0	0
21 to 50 yrs.	0	2	2	6	1	0	2	3
over 50 yrs.	0	0	3	0	1	1	3	3
	1	2	10	12	2	1	8	18
Totals	3		22		3		26	
	25				29			

Of the surviving group of 25 patients, determination of survival in January, 1968, indicated that there had been no recurrence of tuberculosis in individuals who survived the program of treatment. Several patients had substantial but stable neurological sequelae without evidence of progressive disease. None of the patients are now being treated.

TABLE 3

RESULTS OF BACTERIOLOGIC CULTURES FOR *M. TUBERCULOSIS*

Source of Cultures	*Number Positive*
Cerebrospinal fluid	21
Sputum	10
Tissue from autopsy	4
Negative cultures, all sources	19
Total	54

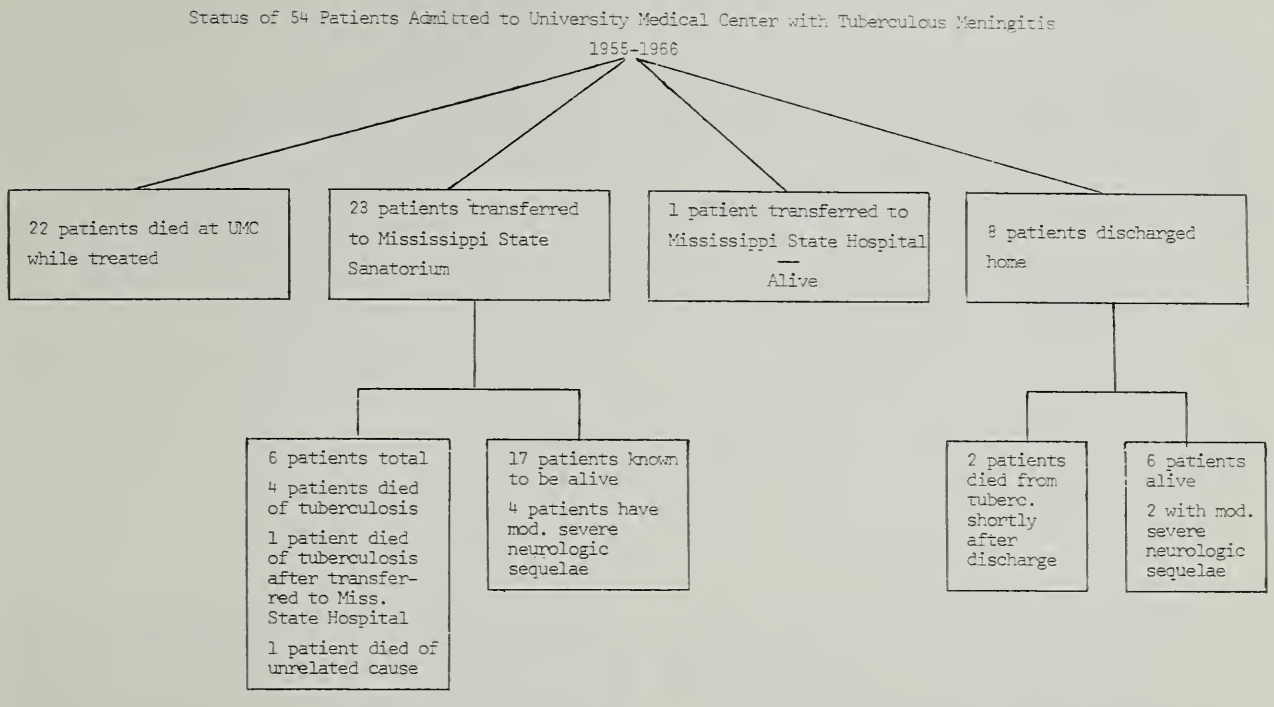
From these retrospective data it was found that from 1 to 10 patients were hospitalized each year for tuberculous meningitis from a population of slightly more than 2,300,000 persons. From Table 1 it may be seen that the diagnosis was made with substantially less frequency for the last 5 years of the 10 year study. Although we have no direct evidence to explain this decline in frequency of recognition of the disease, it may reflect the gradual reduction in new cases of pulmonary tuberculosis seen during the same time.

This experience serves to emphasize graphically that tuberculous meningitis in Mississippi was recently attended by a mortality rate slightly over 52 per cent when all age groups were considered. Almost 70 per cent of children under the age of 5 years died of tuberculous meningitis. There was an even greater mortality rate (73 per cent) for patients in the age group over 50 years. These results are particularly important in view of the fact that combined antimicrobial and glucocorticoid therapy was utilized in every instance.

MORTALITY RATE

Since our mortality rate was much higher than reported from other sections of the United States, it was of interest to look into the reasons for this. Nutrition per se was not thought to be a major factor leading to infection in these patients, although it is known that chronic dietary deprivation can reduce resistance to development of

TABLE 4



tuberculosis.[4] In this regard, it may be relevant that most of the patients (89 per cent) were Negroes and that of these, female children had the highest death rate. This sex difference is similar to death rates due to tuberculosis by age and sex per 100,000 population where there were 2.0 deaths in female nonwhites as opposed to 0.8 deaths in male nonwhites under the age of 4 years.[3] It may be that the high rate of death for female children, therefore, reflected the more frequent occurrence of this disease in Negro girls than in boys. This sex difference was reversed for older age groups (Table 2). In general, it is well known that dark-skinned races control tuberculous infections less well than members of the Caucasian population and our findings were in agreement with this.

The high death rate was most likely due to delayed recognition of the disease. These results resembled the experience of similar studies where advanced tuberculous meningitis responded poorly to therapy.[5] The majority of these patients were indigent, of rural origin and, therefore, of a population group unlikely to have a ready access to medical care at this point in time.

SOURCES PERPLEXING

It was not always possible to determine from our records the source for the tuberculous infection in the pediatric age group. Such cases led to intensive search for other active infections, but the efforts were not always productive. This then would sharply underscore the need for more vigorous case finding programs in this population. Since there has not been a uniform statewide method for detecting new cases of tuberculosis in Mississippi, these data indicate need for expenditure of effort in this direction. The prophylactic or early treatment of children and adults in family groups known to harbor patients with active tuberculosis would have prevented most of these fatalities.

SUMMARY

A retrospective analysis was made of the results of treatment obtained in 54 patients with tuberculous meningitis. Altogether, 29 patients died despite use of an acceptable mode of treatment with three drugs in addition to adrenal glucocorticoids when indicated. Black patients far outnumbered white and the highest mortality was in patients under 5 years of age.

The cause for the high death rate from meningitis was not immediately apparent. It was suspected that delays in seeking medical care inherent in a rural population were the most likely factor responsible for these results. ★★★

2500 North State St. (39216)

This study was supported in part by grant number TG AI 00290 from the National Institutes of Health.

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ETERNAL REVENUE

Two men were stranded on a desert island. One was quite nonchalant and relaxed, while the other was frightened and apprehensive.

"What are we to do?" asked the upset castaway.

"Don't worry," advised his calm counterpart.

"How so?" was the response. "We're out here in the middle of the ocean."

"Oh, they'll find us, all right. I haven't paid my quarterly tax installment yet."

Importance of Technique in Roentgen Examination Of the Small Intestine

CHARLES M. NICE, JR., M.D., Ph.D.
New Orleans, Louisiana

ROENTGENOGRAPHIC STUDY of the small intestine may be quite time consuming, often requiring three to six hours for its performance. A lack of uniform filling or discontinuity of the barium column may lead to an inconclusive diagnosis. Some of the familiar barium preparations are said to show flocculation in the presence of mucus, thus producing an unusual small bowel pattern.

Many suggestions have been made to decrease transit time and improve the diagnostic pattern in a small bowel examination. The properties of barium preparations have been studied.[1, 2] The ingestion of cold saline[3] has been suggested as a means of hastening small bowel transit. Colloidal suspensions of barium[4, 5] have been used to secure a more uniform pattern. The small bowel enema[6, 7] after intubation of the duodenum has been proposed to produce more rapid uniform filling of the small intestine. The use of purgatives[8] and parenteral neostigmine[9] have also been suggested to decrease transit time and improve the diagnostic pattern. More recently, a reflux small bowel study[10] has been proposed in which the patient is given a barium enema, and the small bowel is allowed to fill by reflux through the ileocecal valve.

It has been noticed that with the oral ingestion of 6 oz. or less of the usual barium suspension, the tendency to segmentation is noted, and a period of four to six hours, often more, is required for the study. It was suggested that this difficulty might be obviated by increasing the original barium meal or by giving an additional amount of barium suspension, saline, or water after a given interval of time.

In doing routine fluoroscopy of the stomach, it is often noted that when the patient is in the right lateral recumbent position the stomach empties at a rapid uniform rate. It seemed logical that this position might be used to produce a more rapid and uniform filling of the small intestine.

Many suggestions have been made to decrease transit time and improve the diagnostic pattern in a roentgenographic study of the small intestine. The author discusses a Charity Hospital experimental study. He concludes that a rapid uniform filling of the small intestine and an excellent diagnostic pattern will result from using 10 oz. of orally ingested barium suspended in plain water, followed by the oral ingestion of 10 oz. of water 30 minutes later, and placing the patient in the right lateral recumbent position. He warns that preliminary cleansing of the colon is mandatory for good results.

With this in mind, several clinical experiments on normal subjects[11] were carried out utilizing various volumes of ingested liquid. The use of the upright and right lateral recumbent positions and the effect of using saline, colloidal suspensions, and sodium carboxymethylcellulose as an additive were investigated in small groups of nor-

From the Department of Radiology, Tulane Medical School, and the Department of Diagnostic Radiology, Charity Hospital.

mal subjects. It was found that by giving an adequate volume of liquid and keeping the patient in the right lateral recumbent position the stomach tended to empty at a uniform rate and the column of barium in the small intestine was continuous. However, even with these favorable circumstances, it was noted that the barium did not reach the colon in one hour unless the bowel had been emptied. For this reason it was suggested that the patient be given a laxative or an enema the night before the examination.

TECHNIQUE UTILIZED

After the experiments with normal subjects, a technique was developed which allowed control of the predicted time and mucosal pattern that would be obtained with the small bowel roentgen examination. Preliminary cleansing of the colon is mandatory. A minimum of 10 oz. of orally ingested barium suspension is given, the patient may be fluoroscoped to study the esophagus, stomach and duodenum, and the patient is placed in the right lateral recumbent position to favor a rapid uniform filling of the small intestine with production of a desirable roentgenographic pattern. With this method, the usual plain barium suspension in water may be used to produce an excellent small bowel examination within approximately one hour.

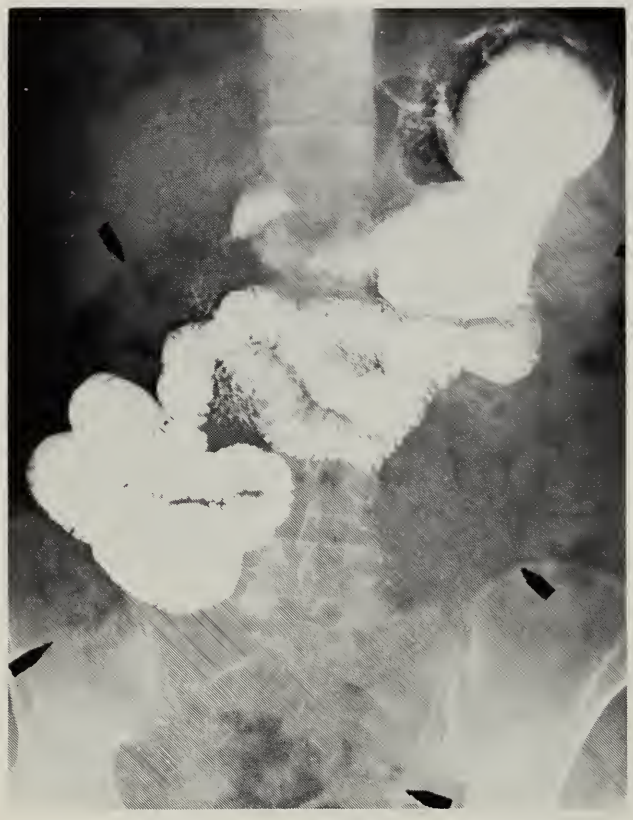


Figure 1. Lack of preparation. This patient has considerable fecal material in the colon. Experiments proved that even with large volumes of barium, the use of saline or special barium preparations, and the assumption of the right lateral recumbent position, the head of the barium column does not reach the colon in one hour unless the bowel has been emptied.



Figure 2a. The colon has been emptied. Exposures at 20, 40, and 60 minutes after ingestion of barium show a continuous pattern of the loops of the entire small intestine. This is the 20 minute exposure.

BARIUM FILM

One roentgenogram of the abdomen is taken 20 minutes after the ingestion of barium. This roentgenogram is taken in the AP view so that there will be an air contrast effect in the gastric antrum which allows one to see the duodenum and upper jejunum through the stomach. The patient is fluoroscoped after 30 minutes to study the possibility of unusual displacement of loops and to see if all of the visualized loops are pliable. At this time the patient may be given a glass of palatable drinking water to keep up the stomach volume and thus continue uniform gastric emptying.



Figure 2b. Same patient as Figure 2a. This is the exposure at 40 minutes after ingestion of barium.



Figure 2c. Same patient as Figure 2a. and 2b. This is the exposure at 60 minutes after ingestion of barium.



Figure 3

Following this, postero-anterior views of the abdomen are taken at 40 to 60 minutes after ingestion of barium. When the barium is seen to enter the ascending colon, a localized spot film with compression is taken over the ileocecal region. If desired, further radiographs may be exposed while the barium is going through the small bowel and into the colon. Usually the head of the barium column reaches the colon within one hour unless the patient has a disease.

Figure 3. Inflammatory ulcer following potassium medication. A routine exposure revealed a moderately dilated loop. Details were then shown with compression.

If there is considerable fecal material in the colon, regardless of the volume of liquid used, or whether the patient is placed in the right lateral recumbent position, the barium column usually will not reach the colon in one hour (Figure 1). On the other hand, when the colon has been emptied, roentgenograms exposed at 20, 40, and 60 minutes after oral ingestion of the barium suspension will usually show a continuous pattern of various loops of the entire small intestine (Figure 2).



Figure 4



Figure 5

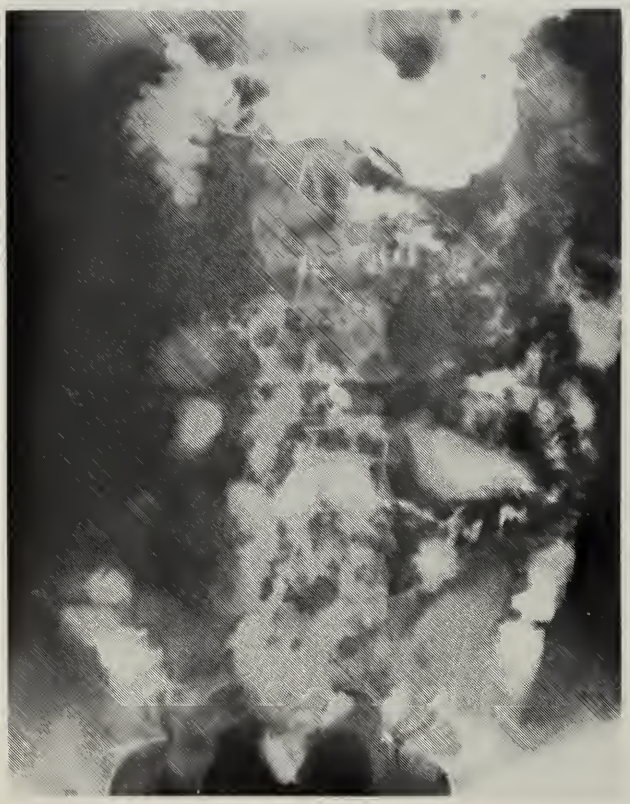


Figure 6

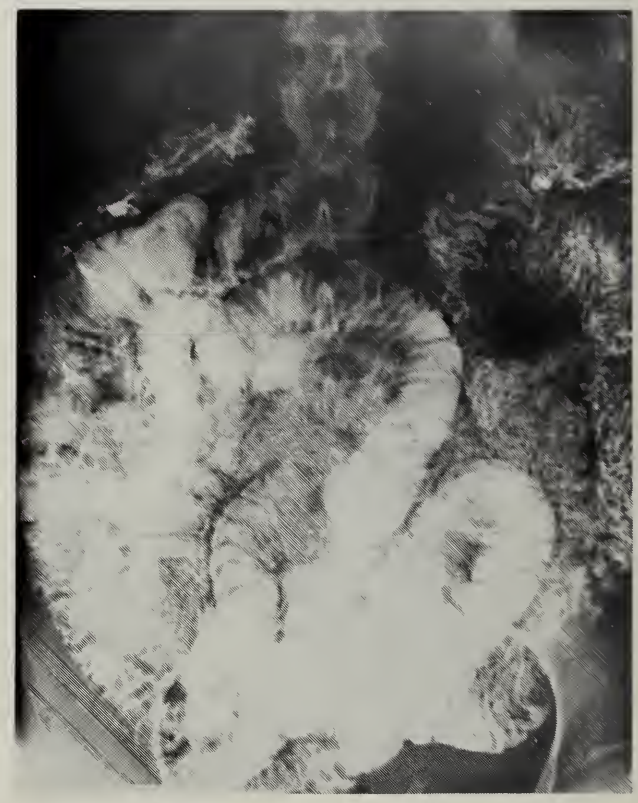


Figure 7

Figures to the left:

Figure 4. Melanoma of jejunum. The localized lesion is well demonstrated because of the continuity of bowel pattern. Rarely the melanoma may be primary but usually careful history and physical examination will reveal most melanomas to the small bowel to be metastases.

Figure 5. Regional enteritis involving several regions of small bowel. This condition may affect single or multiple areas from the duodenum through the entire colon.

Figure 6. Disaccharidase deficiency. This patient, sensitive to milk products, had a relatively normal small bowel study. After the addition of 362 gm. of lactose to the barium meal, the small bowel appears irregularly distended by dilute contrast material. Transit is rapid.

Figure 7. Pancreatic insufficiency. Atrophy of pancreas at autopsy. Non-specific generalized change in small bowel pattern, possibly associated with submucosal edema.



Figure 8

Figures to the right:

Figure 8. Malabsorption with macrocytic anemia. At times the changes are minimal and unless a carefully controlled type of examination is performed, the study may be called normal.

Figure 9. Eosinophilic gastroenteritis. These patients present clinically with eosinophilia, nausea, and vomiting. There may be antral deformity, partial pyloric obstruction, thickening of the jejunal wall and nodular defects due to lymph node enlargement.

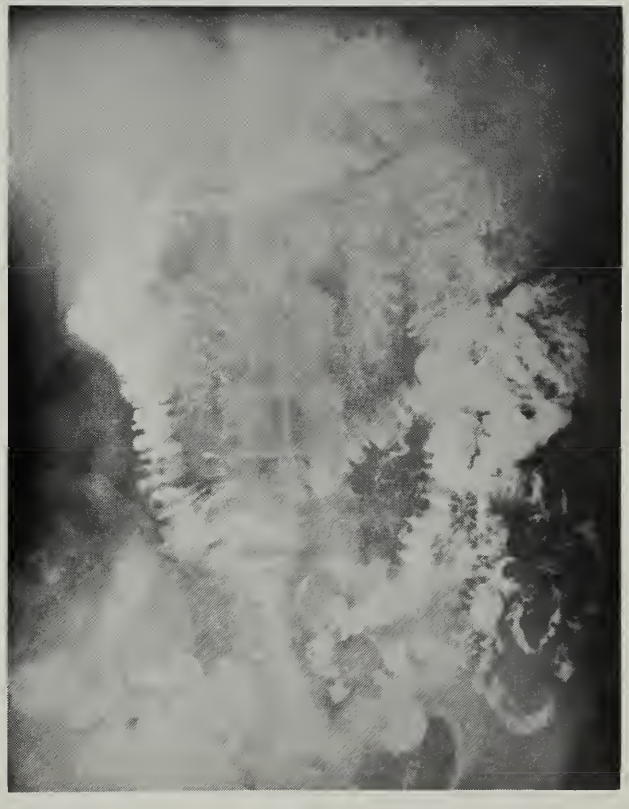


Figure 9

Localized disease processes such as inflammatory ulcer of the small intestine (Figure 3) and primary or metastatic tumor (Figure 4) may be clearly demonstrated.

Diseased conditions with multiple local lesions such as carcinoid, diverticulosis, lymphoma, and regional enteritis (Figure 5) are also very well demonstrated with this method.

There are many conditions which cause a generalized, often non-specific, type of abnormal pattern in the small intestine. These include various collagen disorders, malabsorption syndromes, Whipple's disease, amyloidosis, mucoviscidosis, and many others. With the controlled small bowel roentgen method, the pattern can be readily predicted so that some of the diseases herein illustrated such as hypolactasia (Figure 6), pancreatic insufficiency (Figure 7), malabsorption associated with macrocytic anemia (Figure 8), and such unusual conditions as eosinophilic gastroenteritis (Figure 9) may be well portrayed.

Much useful information may be secured by means of a controlled small bowel roentgen examination.

With preliminary cleansing of the colon and with the subject in the right lateral recumbent position, the use of 10 oz. of orally ingested barium suspended in plain water, followed by the oral ingestion of 10 oz. of water 30 minutes later, will produce a rapid uniform filling of the small intestine resulting in an excellent diagnostic roentgenographic pattern.

Localized, disseminated, and generalized affectations of the small bowel may be well demonstrated with this method. ★★★

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SALUD!

Some argue that beer is a health drink. They contend that if you drink one bottle a day for 1,200 consecutive months, you'll live to be 100 years old.

Radiologic Seminar LXXXIV: Arthrography of the Knee

JAMES B. BARLOW, M.D.
Jackson, Mississippi

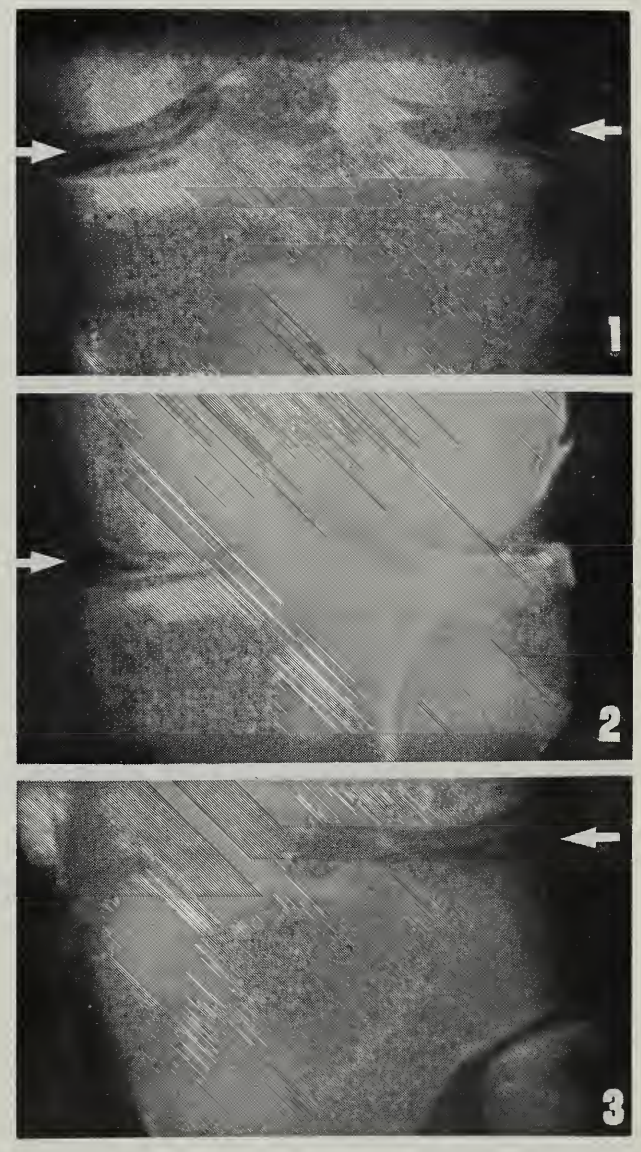
ARTHROGRAPHY IS the visualization of a joint space and its cartilaginous surfaces and adjacent tendons. It is a safe and relatively simple procedure permitting accurate diagnosis of torn menisci. Although the accuracy of clinical diagnosis is high, a definite diagnosis of a torn meniscus is sometimes not possible by clinical means alone. Since there are a significant number of cases with equivocal or atypical clinical findings, this graphic means of demonstrating the meniscus is of value.

Since Bircher[1] first used a combination of gas and positive contrast substance to demonstrate the menisci, several different techniques have been used; however, a horizontal roentgen ray beam as described by Andres and Wehlin[2] and modified and popularized by Freiberger[3] seems to be the safest and most simple method to graphically demonstrate the menisci.

With the use of 20 cc. of air and 6 cc. of glucamine diatrizoate (renografin 60 per cent), patients have little or no discomfort. In a series of over 200 arthrograms, no complications were experienced. If fluid is present in the knee joint, as much as possible should be aspirated and 7 or 8 cc. of renografin 60 per cent should be used.

Using low kilovoltage technique for maximum contrast and short exposure time, filming is performed with deliberate speed and the roentgenograms are inspected immediately. Occasionally it is necessary to repeat one or more projections if a satisfactory tangential view has not been obtained.

The medial meniscus is a concentric cartilage, triangular in cross section. The lateral meniscus is more circular than the medial, but in cross section it is also triangular (Figure 1).



Figures 1, 2 and 3. Left arrows show medial and torn medial; right arrows show lateral and torn lateral.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Doctors Hospital.

Tears present as abnormal collections of contrast substance within the wedge-shaped cross section view of the meniscus and/or as a deformity in the contour of the wedge. Although several basic types of tears have been described, in general torn medial menisci (Figure 2) are seen more frequently.

A torn lateral meniscus (Figure 3) is more difficult to demonstrate and evaluate due to a synovial recess commonly seen anteriorly between the inferior portion of the base of the wedge and the lateral ligament. The margins of these structures, which are normally contrast filled, are smooth and can usually be differentiated from tears.

Although we sometimes do not attempt to classify the tear, we do indicate its location as this is often helpful to the surgeon.

SUMMARY

A torn meniscus is a common lesion and in a significant number of cases a definitive diagnosis is not possible by clinical means alone. In other cases valuable time can be saved by arthrography. Arthrography, using double contrast technique, and horizontal roentgen ray beams, is extremely accurate, perfectly safe, and relatively simple.

Some knowledge of the normal anatomic relationships of the menisci is necessary for interpretation of arthrogram. ★★★

Doctors Hospital

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PRINCIPALLY POSITIVE

The local school board had complained bitterly to the editor of the newspaper that his reporters played up the bad and downgraded the good when writing about the schools. The next day, this news story appeared:

"Today, 324 students were in attendance at the Cherry Elementary School. All showed evidence of careful preparation for the day's lessons, and teachers were enthusiastic about the success of classes.

"Just before dismissal, a student shot and killed the principal."

—Mississippi Educational Advance

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, July 13-17, 1969, New York, N.Y.; Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo. E. B. Howard, Acting Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joseph B. Miller, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 1237, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Mary's Restaurant, Hernando, Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, August, October, December, and May 30. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. Edward Pennington, Ackerman, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

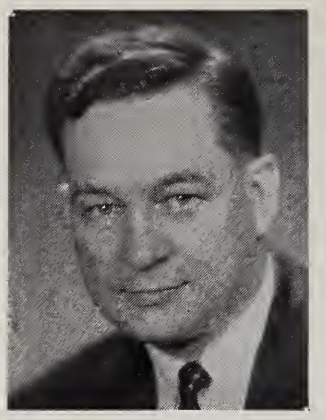
Prairie Medical Society, Second Tuesday, June, September, December, and March 8, 1970. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

Singing River Medical Society, Third Monday January, March, June, September, and December. Donald E. Dore, Singing River Hospital, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. W. B. White, 1007 Jefferson Street, Laurel, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.



The President Speaking

'Carrying the Tasks Forward'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

TWO OF THE MOST difficult duties of the president of our state medical association are writing his first and last pages for our JOURNAL. In his first message to his colleagues, the freshman president is a little apprehensive about what he will say. After a year of intensive activity, he finds that there just isn't enough space on the page to say what he has in mind.

This final message is one of sincere and deep appreciation. I am first grateful to my colleagues, the doctors of Mississippi, because it was you who accorded me this high honor and entrusted me with the respected name of your association and profession. Everywhere Mrs. Rogers and I were privileged to go in your behalf—in almost every region of Mississippi and from California to Florida—we were warmly received.

A special measure of gratitude is reserved for the officers and Trustees of our state association whose work in your behalf is one of devotion and great value. To the officers of the component medical societies, the real grassroots leadership, we all owe heartfelt thanks. And, of course, to the gracious ladies of the Woman's Auxiliary, a special expression of appreciation is made.

Medicine and medical organization are no longer arts, sciences, and structures of simplicity; they are unbelievably complex and becoming more so. We physicians must now reckon with the pressures of society, programs of the politicians, the cry of the consumer, and the economic juggernaut of insurance, prepayment, and government. It is a time to put our best foot forward, to assign our best leaders to the tasks, and to give our strongest support. I am grateful for my year, and I will soon join you in carrying the tasks forward from the grassroots. ★★★

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EDITORIALS

Blue Cross Chief Makes Strong Medicine

I

TWO AMAZING MEN have come from the halls of the University of Michigan at Ann Arbor: They are Wilbur Cohen and Walter J. McNerney. Professor Cohen is back at his academic post after an eight-year tour in Washington. He was the chief architect of Medicare. McNerney is president of the Blue Cross Association, more frequently than not described as the biggest single pillar in the house of voluntary, private medical care financing. But McNerney has some ideas which make Professor Cohen sound like a Texas conservative discussing oil depletion allowances.

The Blue Cross chief advocates slashing reforms for reorganization of the health care system in the United States. This alone does not make him unique; there are others who disapprove of the private care delivery system. But McNerney wants more federal participation in health care and apparently more economic muscle for Blue Cross to enforce the new system. He says that "we need national guidelines and local implementation," contending that neither the federal government nor the private health sector has the money or competence to do the job alone.

There is word abroad in the land that not every Blue Cross plan or executive agrees with President McNerney. And, quite properly, the internal opinion of the Blue Cross Association is of no concern to consideration of McNerney's views and goals. As an individual of high intellectual attainment, he is aware that his public statements will be the subject of editorial comment. We examine only what he says.

II

In a smaller sense, this spectrum of ideas encompasses the hospitals, because Blue Cross is of immeasurable importance to their operation. It almost invariably does a good job, showing honorable stewardship of the prepayment, hospital care dollar. But if this same economic juggernaut were diverted to purposes of compulsion upon patients, institutions, and physicians, then the context of the discussion should have been considerably altered.

President McNerney advocates reorganization of the care delivery system in three developments: Group practice of medicine, the "campus concept" of facilities and services, and neighborhood health centers.

Group practice as a format of professional partnership is not bad *per se,* but any move to compel physicians into group situations along the lines of the so-called prepaid groups and to deny patients the right to hire and fire their own doctors would hardly bring a medical society's house

of delegates to a standing ovation. In fact, the system might not win too many popularity contests among patients who like to choose their physician and name the hospital to which he admits them.

The campus concept is among the newer innovations suggested in reorganizing medical care delivery patterns. It centers around the idea of bunching a range of medical institutions and services in one location, a sort of supercenter. But it can be logically argued that since bigness is not necessarily bad because it is big, neither are the small hospital and solo practitioner bad just because they are little.

The neighborhood health centers, McNerney says, will require "large infusions of government money through the OEO, Housing and Urban Development, and the Department of Health, Education, and Welfare." Experience has yet to demonstrate the necessity for or wisdom of such a program.

III

The principal tool which McNerney would employ in this massive shakeup is areawide planning of facilities. He said that organizations like Blue Cross "could relate their payments to community needs by paying less to institutions not involved in areawide planning." He also advocates application of the principle to physicians, urging that payments to doctors be related to areawide planning involvement of providers and that their target rates be negotiated between insurance carriers and them. He warned of making full payment to providers "in the absence of competitive checks and balances. . . ."

He has criticized what he describes as overspecialization in medicine and the allied professions. In fact, he adds, "certain professions are perpetuated that no longer are needed."

McNerney caps off his recommendations by calling for a Council of Health Advisers, a body which would advise the President of the United States in matters pertinent to health and welfare problems of society. "Such a council," President McNerney continues, "could formulate broad goals, establish performance indicators, and evaluate progress." To many, this may have an ominous sound, because for the most part, American medicine has consistently warned against national standards as being inimical to the best care.

IV

McNerney calls for strengthening and broadening health insurance coverage, increasing the effective amount in benefits to 80 per cent from the present 35 per cent. He would accomplish this in two ways: Make payments to the needy in which government help would be inversely related to the individual's income and second, by creation of an employer and employee payroll tax whose funds would be used to purchase basic health benefits from private insurers such as Blue Cross.

The Blue Cross chief is making strong medicine for America's health needs. To create deliberately a system of economic sanctions through which to enforce planned health services might also include creation of tyranny of compulsion, the exact opposite of voluntarism. And whatever may be said of it, private care financing, the largest single component in the financing of medical services, is unique because it is voluntary. In fact, it is difficult to see how McNerney's competition could proceed out of a pattern of top-down compulsion.

Part of the excellence in medical care comes from the patient's being able to choose who will take out his appendix and in what hospital. The voluntary effort of a state in marshaling its health resources, taking care of those who really need help, and assuring the independent integrity of its physicians, hospitals, and health care team is the order of the day. President McNerney is in another day, at another time, and in another place.—R.B.K.

Sock It to Me: 100 Decibels Plus

Offhand, one would not consider three guitars and a set of drums a prime unit of noise pollution, but the experts are finding that they are. The trick is to add a few hundred watts of amplification, and the result is 1969 rock and roll at its loudest. Moreover, the experts are discovering that what turns on the swinging generation may also be making them deaf.

A few jazz buffs may remember the old Count Basie band at the little Famous Door Restaurant in New York during the late 1930's where those four lusty trumpet players, supported by three equally strong men on trombone—all with no pulmonary problems—blasted the soup out of the plates. But the audiologists are discovering that the rock and roll groups can out-decibel the Count.

James Flugrath, an audiologist at the Memphis State University Speech and Hearing Clinic, taped 10 different rock groups playing in a local dance hall. He found that each exceed noise levels considered to be the lowest damage risk criteria in industry. The loudest band exceeded exposure limits in five minutes, whereas the "quietest" made the grade in just over an hour. Some of the musicians tested showed hearing loss up to 25 dB.

The National Broadcasting Company's "First Tuesday," a newsmagazine format program, carried a report last month of similar investigations. Audiologists and otologists said in this presentation that such hearing losses are permanent. As did Flugrath at Memphis, they recommended earplugs.

Youngsters who frequent the discotheques and rock and roll sessions are also turning up with hearing impairment. Nobody wants to be a killjoy, but surely, the youngsters can turn the volume down to safe levels. The precious sense of hearing may be at stake.—R.B.K.

In the Shoes of the Government

What otherwise might have been casually dismissed as another domestic squabble before local courts has become a major precedent in the administration of public medical care programs by private organizations under contract to the government. The action involved a Part 1-B carrier in the Medicare program.

A physician's wife had been awarded separate maintenance following litigation over a domestic matter, and the court had ordered the physician to pay certain amounts monthly for support of the wife. To secure the amounts, the wife initiated further litigation, attempting to garnish funds due the physician for services rendered under the Medicare program. She sued to have the Part 1-B carrier divert to her professional compensation due the doctor.

The carrier acted to have the suit removed to federal court, contending that it, even as a private corporation, was an agent of the federal government. The federal court dismissed the suit, ruling that the action was, in effect, a suit against the government to which it had not consented. The key in the ruling is this: A suit, however styled and captioned, is a suit against the government if the judgment sought would expend itself on the public treasury or interfere with the public administration.

At trial, the government showed successfully that the garnishment, if granted, would increase the costs of administration of the program and cause disruption of the principal tasks of adjudicating and paying claims. The added costs, the government argued, would "expend itself in the public treasury and interfere with the public administration."

Another precedent was established when the court ruled that the contractor, a private corporation, stands in the shoes of the government, since it disburses funds belonging to the government. The precedent is important to voluntary health insurance and prepayment organizations, medical societies, and others who administered public funded programs. Despite the circumstances of the ruling, it appears to assure the physician who has rendered service under such a program that his professional compensation may not be diverted from him through action of state courts.—R.B.K.

Count the Calories— and the Cyclamates

It isn't enough to count the calories nowadays, according to some sources; it may be prudent to count the cyclamates, too. While the facts thus far as to hard contraindications against the artificial sweeteners are inconclusive, enough dust has been raised on the scientific horizon to bring serious and thoughtful opinion to bear.

In Great Britain, for example, a number of major supermarket chains now refuse to sell food or beverages containing cyclamates, saccharin, or dulcin, the three principal non-nutritive sweeteners. They argue that research has shown the agent unsafe in laboratory animals. In Japan, a research study reports that the sweeteners, administered to experimental mice during early pregnancy, killed or retarded growth of the fetuses.

AMA reports only one symptomatic effect of cyclamates in man, a moderate softening of the stools occurring with a daily intake of 5 gm or more. Children appear to be more sensitive than adults to this effect.

In the United States, there are no legal restrictions on artificial sweeteners. Americans consume about 17 million pounds of cyclamates annually, mostly in low calorie soft drinks. But the Food and Drug Administration has not been insensitive to the matter, and in 1968, FDA

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

quietly asked the National Academy of Sciences to investigate.

The NAS committee came up with an interim report advising that "cyclamate sweeteners should not be used in totally unrestricted amounts." The NAS report said that adults can consume up to 5 gm of cyclamates a day without any probable hazard. Children, the report stated, should use proportionately less. FDA says that the cyclamate content of carbonated soft drinks ranges from ¼ gm to slightly more than 1 gm per 12 fluid ounces.

In a joint report with the National Research Council, NAS pegged the safe cyclamate intake level at 70 mg/kg of body weight per day. This report also stated, in contrast with information from Great Britain and Japan, that in animal studies "no effects have been observed that can yet justify any serious suspicion of adverse effects at current consumption levels in man."

If the critics are correct, we'll have to modify the old saw that everything bad for us is illegal, immoral, or fattening.—R.B.K.

PERSONALS

Aubrey V. Beacham of Magnolia, N. A. Bologna of Greenville, and Julian Wiener of Jackson have been named chairmen of the 23rd Annual Tulane Alumni Fund drive for their respective areas. Dr. Beacham's area includes McComb, Magnolia, and Summit, while Dr. Bologna has been assigned the Greenville area and Dr. Wiener, the Jackson area. Each has already conducted kick-off meetings.

Julian T. Janes of McComb reigned as king of the recent Junior Auxiliary Azalea Ball. The occasion, timed with the blooming of the azaleas for which the area is famous, is a highlight of the spring social season.

Ben B. Johnson and Herbert G. Langford of Jackson have been elected to Fellowship in the American College of Physicians. Named to associate membership in ACP are Joseph Glasgow, Richard G. Hutchinson, S. H. McDonnieal, Jr., Roland B. Robertson, Jr., and Robert E. Tyson, all of Jackson, and John R. Shell of Vicksburg and Frederick E. Tatum of Hattiesburg.

George H. Martin of Vicksburg appeared as principal speaker at a recent seminar of the Mississippi Association of Insurance Agents. Subject of the study session was an in-depth review of workmen's compensation. Dr. Martin is the surgical member of the Committee on Occupational Health of the state medical association and associate editor of the Journal.

Lamar Puryear, Jr., has been named to membership on the Board of Trustees of the Hazlehurst Municipal Separate School District. He has actively practiced at Hazlehurst for 16 years and previously served as a city alderman.

David D. Richardson of Louisville has announced his candidacy for election to the city's board of aldermen. He is an alumnus of Mississippi College, Mississippi State University, and the Tulane University School of Medicine.

James E. Safley of Brookhaven has announced an extension of county public health services with the opening of a clinic at Monticello which will be conducted on Thursdays.

James Grant Thompson of Jackson has been elected president of the Southeastern Dermatological Association during the recent annual meeting at Birmingham. The association covers the southeast from Maryland to Florida and west to Louisiana. Dr. Thompson is a past president of the Mississippi State Medical Association.

David B. Wilson has been named president of the Jackson Rotary Club. He is immediate past president of the American Hospital Association and the director of University Hospital.

POSTGRADUATE CALENDAR

CIRCUIT COURSES

Physicians in the Meridian area will host their final postgraduate education Circuit Course May 6. Topics for the dinner meeting will be eye ground manifestations of systemic disease and thyroid problems in infants and children. Dr. Samuel Johnson, clinical associate professor of surgery (ophthalmology) and Dr. Jose Montalvo, associate professor of pediatrics, will speak at 6:30 p.m. at Meridian's Northwood Country Club.

FUTURE CALENDAR

May 6
Circuit Course, Meridian

May 12-15
Mississippi State Medical Association

May 23-24
Automation in Medicine

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

Bradford, William Meredith, Jackson. Born Jackson, Miss., July 13, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned University of Colorado School of Medicine, Denver, one year; urology residency University Medical Center, Jackson, Miss., July 25, 1964-July 24, 1968; elected Dec. 3, 1968, by Central Medical Society.

Campbell, Johathan Cross, Centreville. Born Natchez, Miss., Jan. 4, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned USAF Hospital, Keesler AFB, Miss., one year; elected March, 1969, by Amite-Wilkinson Counties Medical Society.

Carruth, Edward Leston, Jackson. Born Brookhaven, Miss., Oct. 11, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Miss. Baptist Hospital, Jackson, one year; elected Jan. 7, 1969, by Central Medical Society.

Depoyster, James Harold, Moss Point. Born Corinth, Miss., Feb. 6, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Erlanger Hospital, Chattanooga, Tenn., one year; elected March 1, 1969, by Singing River Medical Society.

Deraps, Gordon Douglas, Jackson. Born Biddeford, Maine, Jan. 30, 1934; M.D., University of Texas Medical Branch, Galveston, 1959; interned Santa Rosa Hospital, San Antonio, Texas, one year; medicine residency University Medical Center, Jackson, Miss., July 1, 1959-June 30, 1960 and July 1, 1962-June 30, 1964; Fellowship, same, July 1, 1964-June 30, 1967; elected Dec. 3, 1968, by Central Medical Society.

Donald, Robert Lavalle, Pascagoula. Born Meridian, Miss., June 15, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned USAF Hospital, Carswell AFB, Texas, one year; elected March 1, 1969, by Singing River Medical Society.

Doster, James Thomas, Columbus. Born Gadsden, Ala., July 27, 1937; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned Charity Hospital, New Orleans, La., one year; obstetrics and gynecology residency, Baylor University, Houston, Texas, July 1, 1963-June 30, 1966; elected Dec. 10, 1968, by Prairie Medical Society.

Elliott, Wayne Gordon, Vicksburg. Born Monroe, La., Nov. 5, 1936; M.D., Louisiana State University School of Medicine, New Orleans, La., 1961; interned Southern Pacific General Hospital, San Francisco, Calif., one year; anatomical and clinical pathology residency, Charity Hospital, New Orleans, La., July 1, 1962-June 30, 1966; elected Jan. 14, 1969, by West Mississippi Medical Society.

Flechas, Enrique, Natchez. Born Colombia, South America, Jan. 20, 1935; M.D., National University of Colombia, 1960; interned San Juan de Bios, Bogota, Colombia, 1961; obstetric residency, Mayo Clinic, Colombia; public health residency, 3 months; surgery residency, St. Teresa Hospital, Colombia, 1 year; residency, Natchez Charity Hospital, Natchez, Miss., July 1, 1963-August 1, 1967; elected Feb. 1, 1969, by Homochitto Valley Medical Society.

Gates, William Carey, Jr., Columbus. Born Greenville, Ala., Nov. 2, 1937; M.D., Medical College of Alabama, Birmingham, 1963; interned Carraway Methodist Hospital, Birmingham, one year; urology residency same, July 1, 1965-Sept. 3, 1968; Flight Surgeons School, Brooks AFB, San Antonio, Texas, 9 weeks; elected March 4, 1969, by Prairie Medical Society.

Gordon, James Don, Jackson. Born Philadelphia, Miss., March 26, 1936; M.D., Tulane University School of Medicine, New Orleans, La., 1961; interned University Medical Center, Jackson, Miss., one year; otolaryngology residency, Charity Hospital, New Orleans, La., July 1, 1962-June 30,1966; elected Jan. 7, 1969, by Central Medical Society.

Hancock, George Marvin, Gulfport. Born Russellville, Ky.; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1961; interned same, one year; surgery residency, University of Va. Hospital, Charlottesville, July 1, 1962-June 30, 1963; surgery residency, University of Iowa Hospital, Iowa City, July 1, 1965-June 30, 1968; elected Jan. 8, 1969, by Coast Counties Medical Society.

Hilbun, Glyn Roy, Moss Point. Born Lucedale, Miss.; M.D., University of Mississippi School of

Medicine, 1962; interned University of Texas Medical Branch Hospital, Galveston, one year; medicine residency, University Medical Center, Jackson, July 1, 1963-Dec. 31, 1963; surgery residency, same, Jan. 1, 1964-Dec. 31, 1967; elected March 1, 1969, by Singing River Medical Society.

JOFFE, IRWIN, Biloxi. Born New York City, New York, Dec. 30, 1921; M.D., Tulane University School of Medicine, New Orleans, La., 1944; interned Springfield Hospital, Springfield, Mass., one year; pathology residency, University of Kansas Medical Center, Kansas City, Kansas, Nov., 1951-Nov., 1957; elected Jan. 8, 1969, by Coast Counties Medical Society.

JOHNSON, SOL ESCOL, JR., Moss Point. Born Chicago, Ill., Feb. 28, 1930; M.D., Howard University, Washington, D. C., 1956; interned Homer A. Phillips Hospital, St. Louis, Mo., one year; elected March 1, 1969, by Singing River Medical Society.

KIRK, ANDY ELLZEY, Starkville. Born Doddsville, Miss., Oct. 8, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Mobile General Hospital, Mobile, Ala., one year; residency, Naval Aerospace Medical Institute, Pensacola, six months; elected Dec. 10, 1968, by Prairie Medical Society.

LADNER, GEORGE DALE, Jackson. Born Biloxi, Miss., Feb. 22, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Wilford Hall Hospital, Lackland AFB, Texas, one year; psychiatry residency, University Medical Center, Jackson, Miss., July 1, 1965-June 30, 1968; elected Jan. 7, 1969, by Central Medical Society.

LONG, WILLIAM ALEXANDER, JR., Jackson. Born April 20, 1930, Gallman, Miss.; M.D., Tulane University School of Medicine, New Orleans, La., 1955; interned Colorado General Hospital, Denver, one year; pediatric residency, same, July 1, 1965-June 30, 1967; elected March 4, 1969, by Central Medical Society.

LOTT, ROBERT TOWNSEND, West Point. Born Kilmichael, Miss., Dec. 16, 1931; M.D., University of Tennessee College of Medicine, Memphis, 1956; interned Baptist Memorial Hospital, Memphis, Tenn., one year; surgery residency, Kennedy V. A. Hospital, Memphis, Sept. 1, 1960-Jan. 1, 1963 and July 1, 1966-June 30, 1968; elected March 4, 1969, by Prairie Medical Society.

MCKELL, WILLIAM MCARN, JR., Jackson. Born Oxford, Miss., Oct. 26, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Wilford Hall USAF Hospital, San Antonio, Texas, one year; medicine residency, University Medical Center, Jackson, Miss., July 1, 1965-June 30, 1968; elected Dec. 3, 1968, by Central Medical Society.

MARASCALCO, CHARLES ANTHONY, Vicksburg. Born Grenada, Miss., Oct. 6, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned same, one year; medicine residency, same, July 1, 1964-June 30, 1967; gastroenterology fellowship, same, July 1, 1967-June 30, 1968; elected Jan. 14, 1969, by West Mississippi Medical Society.

STITH, JAMES LOGAN, Gautier. Born Louisville, Ky., Dec. 7, 1929; M.D., George Washington University School of Medicine, Washington, D. C., 1956; interned Garfield Memorial Hospital, Washington, D. C., one year; residency same; elected March 1, 1969, by Singing River Medical Society.

WALLER, THOMAS EUSTACE, Starkville. Born Greenwood, Miss., Feb. 7, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Miss. Baptist Hospital, Jackson, one year; elected Dec. 10, 1969, by Prairie Medical Society.

DEATHS

MCMILLAN, AMON KENNEDY, Lucedale. M.D., Medical College of Alabama, Birmingham, 1909; fellowship, Tulane University, New Orleans, Louisiana, 1939; member MSMA Fifty Year Club; died March 28, 1969, aged 85.

PARSONS, WILLARD HERRING, Vicksburg. M.D., Jefferson Medical College, Philadelphia, Pa., 1920. Fellow, American College of Surgeons; ACS Governor for Miss.; member, ACS Board of Governors; chairman, ACS Board of Governors; Regent, American College of Surgeons. Member, Southeastern Surgical Congress; Southern Society of Clinical Surgeons (president); Southern Surgical Association (vice president); Western Surgical Association; American Surgical Association; Societe Internationale de Chirurgie. American Cancer Society, Mississippi Division, president and national delegate. Consultant to the

Surgeon General, U. S. Army, 1962. Diplomate, American Board of Surgery, and member, Founders' Group of the Board. Died March 9, 1969, aged 71.

PURYEAR, HARRY HENTON, Koscuisko. M.D., Vanderbilt University College of Medicine, Nashville, Tennessee, 1913; interned U. S. Army Hospital, 1918, Natchez Charity Hospital, 1939; died March 10, 1969, aged 79.

AHA Reports Rise in Hospital Costs

Expenses incurred by hospitals in providing one patient with one day of care in 1968 averaged $65.24, according to Hospital Indicators published in the *Journal of the American Hospital Association*. This represents a 12.4 per cent increase over the 1967 average daily expense of $58.06.

Hospitals in 1968 employed more people and paid them higher wages than ever before, AHA said. The average annual wage paid to hospital employees in 1968 was $5,513, or $488 more than the $5,025 paid in 1967.

As a result, payroll expense per patient day increased by 12.9 per cent in 1968 over 1967—from $36.30 to $40.97. The number of employees on the payrolls increased by 6.8 per cent to 1.7 million persons. There are now 272 hospital workers for every 100 patients, while in 1967 there were 264 employees for every 100 patients.

While payroll is their biggest expense, hospitals also incur expenses for equipment, services, supplies, employee fringe benefits and other items. In 1968, total expenses for the nation's 5,850 community hospitals were $14.7 billion, or $2.1 billion more than in 1967.

The public continues to make more use of hospitals' services and facilities and this is a factor in increased expenses, according to Hospital Indicators.

The number of admissions to hospitals during 1968 increased by 2.1 per cent to a total of 27,768,383, of which 5,711,489 were patients 65 years of age and older. A more significant increase was reported in the outpatient departments of the nation's community hospitals, where visits totaled 111,182,245 for the year, or a 6.7 per cent increase over the 1967 total.

The frequency with which the nation's population uses hospital outpatient services reflects an increasing tendency to regard hospitals as community health centers where a wide range of health care services are available.

Persons admitted to hospitals stayed an average of 8.1 days in 1968. However, the average length of stay for persons 65 and over was 13.4 days—up from 13 days in 1967. Patients under 65 remained hospitalized an average of 6.8 days, or the same as in 1967.

The average daily census in all community hospitals last year was 616,511 and the occupancy rate stood at 78.5 per cent. That compares with the 1967 figures of 595,667 and 78.1 per cent.

For the seventh straight year, the number of births in hospitals declined. The total for 1968 was 3.12 million, compared with 3.15 million in the previous year.

SK&F Will Code Packages, Products

Smith Kline & French Laboratories has adopted a new system of numbering its drug product packages and is beginning to imprint the new product numbers on all labels and shipping cases. Starting next fall, product identification codes will be imprinted on individual tablets and capsules.

Donald van Roden, vice president and general manager—pharmaceuticals, said that the changes represent a corporate effort to "help show the way toward more positive, definitive product identification." SK&F is making the changes, he added, "not because we have to, but because we ought to."

Every SK&F drug product has been assigned a new identification number consisting of five characters. The first three characters—an alphabetic letter and two digits—represent product, form and strength. The last two characters—both digits—represent package size.

By 1970, the three-character code representing product, form and strength will be imprinted on every tablet and capsule coming off the SK&F finishing line.

SK&F's new product numbers conform to the National Drug Code developed recently by representatives of the drug industry in cooperation with the Food and Drug Administration. This uniform Code, which most pharmaceutical manufacturers have agreed to adopt, employs a maximum of nine characters to identify product, form. strength, package size and manufacturer.

Rare Historical Records of Vicksburg Medical School Go to SBH Library

A retired Jackson physician has turned over to the State Board of Health library his written recollection of an obscure chapter in Mississippi medicine in which he was a participant.

That was the 1909-10 academic year, when juniors and seniors of the University of Mississippi medical department attended classes at Vicksburg. The arrangement lasted only one year.

"We're always glad to get such personal recollections," says Miss Louise Williams, State Board of Health librarian, "especially on events about which very little has been written."

The essay on the year at Vicksburg was written by Dr. J. H. Fox, who retired 18 years ago, at the age of 70, after a long medical career in general practice, with special attention to nervous diseases.



Dr. J. H. Fox of Jackson, left, discusses his personal collection of references and history on the Vicksburg medical school with State Health Officer H. B. Cottrell and Miss Louise Williams, Board of Health librarian.

The Vicksburg faculty of eleven physicians outnumbered their student body, which included four seniors (who graduated on May 20, 1910) and five juniors.

Dr. Fox, who is in good health, is the only surviving member of that faculty. And Dr. Isaac C. Knox, of Vicksburg, is the only survivor of the student body of the Vicksburg year.

Dr. Fox recalls that freshmen and sophomores took medical classes on the Ole Miss campus but went outside the state for junior and senior studies, since hospital facilities on the campus were limited.

Charity Hospital at Vicksburg offered the kind of facilities needed, and Dr. Fox says "It was the dream of Dr. W. S. Leathers and Chancellor A. A. Kincannon" to institute junior and senior classes.

"Dr. Leathers got in touch with the city fathers of Vicksburg," Dr. Fox recalls. "And, with the help of the board of supervisors of Warren county, these contacts soon produced results."

The university bought the hospital and built an addition to provide sufficient space for classrooms, and this fact was announced in the university magazine in an advertisement signed by Chancellor Kincannon.

The ad said third and fourth-year courses would be given in Vicksburg in connection with the hospital, "which has recently been enlarged and renovated. Every facility for the best clinical and laboratory work will be offered."

An article in the "Mississippi Medical Monthly" issue of March, 1909, also described the fact that third-year and fourth-year students would stay in Mississippi for the 1909-10 session, adding:

"The work in these two years will be done at Vicksburg in connection with the University Hospital, a well-equipped institution of about one hundred and fifty beds, adjoining with the buildings of the department, for which contracts are being let, will be situated."

The faculty was listed as Dr. H. H. Haralson, theory and practice of medicine; Dr. B. B. Martin, surgery and gynecology; Dr. E. F. Howard, obstetrics and pediatrics; Dr. Sylvan Myers, therapeutics and clinical medicine; Dr. S. W. Johnston, operative and clinic surgery.

Assistants in these branches and clinical instructors were listed as doctors J. A. K. Birchett, H. F. Sproles, Jr., J. S. Ewing, V. Bonelli, M. H. Bell, J. H. Fox, L. B. Austin "and others not yet selected."

There may have been some changes in faculty between the time that list was announced and the opening of classes in September, because Dr. Fox remembers a slightly different faculty, as follows:

Dr. H. H. Haralson and Dr. J. S. Ewing, medicine; Dr. S. W. Johnston, Dr. B. B. Martin and Dr. Henry Sproles, surgery; Dr. E. F. Howard, obstetrics and gynecology; Dr. Charles Edwards, eye-ear-nose-throat; Dr. Sylvan Myers, therapeutics and materia medica; Dr. V. E. Bonelli, diagnosis; Dr. C. L. Stingley, pathology and laboratory; and Dr. J. H. Fox, dermatology.

Dr. Fox recalls that Dr. Leathers "got in touch with practicing physicians in Vicksburg, and they agreed to take special courses to qualify them as instructors. For example, I went to Philadelphia an took special courses in dermatology at the Jefferson Medical College for that purpose. Dr. William Krauss came down from Memphis to serve as dean of the school."

Dr. Fox remembers the only four seniors who ever graduated from the Vicksburg school as J. C. Herrington, Sandersville; G. W. Montgomery, Louin; William A. Walton, Binnsville; and L. K. Mayfield (no address listed). The juniors were J. L. Nichols, Alligator; Hal Johnson, Dundee; J. C. Watkins, Jonestown; A. L. Smith, Meridian; and I. C. Knox, then of Pontotoc, now in Vicksburg.

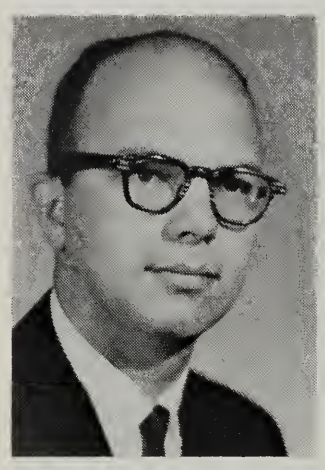
As to why the school in Vicksburg lasted only a year, Dr. Fox writes that "The state legislature got into a wrangle over the election of a United States Senator to fill the place of a Senator who had died. As a result, the legislature adjourned without making an appropriation. So the medical department at Vicksburg closed after one session. And it remained closed until the present University of Mississippi Medical School opened here in Jackson."

Born at Bovina (his father was a railroad agent there), Dr. Fox graduated from Memphis Hospital Medical College, interned one year there at the U. S. Marine Hospital, practiced "as a country physician" in Warren and Hinds counties and served one year as county health officer for Warren county.

He then served on the faculty of the school at Vicksburg, after which he moved to Jackson, where he served for eight years on the staff of the State Institution for the Insane. He was in charge of the white female disturbed ward, and he became assistant superintendent of that institution. He served a year as a captain in the Army Medical Corps, returned to Jackson and entered private practice until 1924, when he became a medical specialist on the pension rating board for the Veterans Administration in Jackson. He was with the Veterans Administration until he retired at 70, but he continued to serve on an annuity basis until 1959.

Mathews Resigns MSMA Executive Post

Charles L. Mathews resigned his post as associate executive secretary of the Mississippi State Medical Association, effective April 15. This was the joint announcement of Dr. Joseph B. Rogers, president; Dr. C. D. Taylor, Jr., chairman of the Board of Trustees, and Rowland B. Kennedy, executive secretary.



Mr. Mathews

Mathews has assumed new duties in the Office of Federal-State Relations, an agency of state government at Jackson, with assignment to the recently created Division of Comprehensive Health Planning.

The association officials, in making the announcement, said that "Mathews has made many substantial and valuable contributions to the state medical association and to the profession, and we wish him success in his new work."

The 36-year-old executive is a veteran of nine years with the association, being appointed assistant executive secretary in May 1960. He was promoted to the newly created post of associate executive secretary a year ago.

In recent years, Mathews' assignments includ-

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ed those of staff director for the councils on Medical Service and Scientific Assembly, operations manager for the CHAMPUS program, and director of the Physicians Placement Service. He played a key role in the production of the JOURNAL, handling liaison with authors and various technical phases of printing.

Mathews is a native of Jackson and a graduate of the Louisiana State University. He was in the military service 1952-1955 and is married to the former Miss Phoebe Quaintance of Silver Spring, Md. They have two sons, Charles, Jr., and John Howard, and a daughter, Lacey. They will continue to reside at 1951 Hamilton Blvd. in Jackson.

'Cell Switch' May Be Cancer Finding

An internal chemical switch which shuts down the protein factory in crowded masses of normal cells has been found by University of Rhode Island scientists, but cancerous human and mouse cells appear not to produce the substance or to react to it.

"Since any cell is capable of becoming cancerous, the knowledge gained about normal cells and their structure or internal functions could be useful in solving the problems of cancer," Dr. Harold W. Fisher, URI professor of biophysics, explained.

Reporting in the current issue of the *Journal of Cell Biology,* he and Dr. Jen Yeh, a former URI graduate student now at the National Institutes of Health, Bethesda, Md., explained that a chemical inhibitor or switch has been obtained from dense cultures of mouse cells. When this chemical is present, normal cells stop dividing.

They believe that the chemical is produced within healthy cells and leaks out when cell walls come into contact with one another. Dr. Fisher suggests that molecules with high electrical charges on the cell's surface may act like sharp prongs to make the cell walls porous.

However, on the walls of human cancer cells, URI researchers have photographed hair-like structures called microvilli which may serve to keep cells apart.

These facts may help explain why some cancer cells are not adhesive and can migrate throughout a body, invading healthy tissue and organs, he theorizes.

Pictures of the microvilli were obtained at 20,400 magnifications using a special process on the electron microscope. Clear pictures of these structures were first obtained in 1967 by URI scientists who devised a new combination of existing techniques.

In the electron microscope, an electron beam is used rather than light rays to eventually produce a visible image, but electrons will not penetrate tissue, even one cell thickness to give the type of picture sought. Therefore, cells to be viewed are freeze-dried in a vacuum much like the instant bananas in breakfast cereals. These cells are then vacuum coated with atoms of Paladium and Platinum followed by another layer of Carbon. Finally the cell itself is digested away leaving a thin replica of the cell which can be probed by electrons.

Work is now underway in an attempt to isolate and identify the chemical inhibitor. In preliminary tests, it has been possible to concentrate the substance and Dr. Fisher believes it may be a polyamine, an organic substance of low molecular weight.

The evidence, according to Dr. Fisher, is that the chemical interferes with the production or synthesis of RNA (ribonucleic acid). RNA carries a coded message from the cell's nucleus where the master plan of the entire organism is kept. By following this genetic code the outer portion of the cell manufactures a duplicate cell which splits off and after many such divisions eventually becomes part of that living thing.

Colonies of cells growing in a broth of sugar, amino acids, vitamins, salts and blood serum were tested to determine whether the preliminaries to cell division were taking place. This was accomplished by dunking them in a compound containing radioactive Carbon or Tritium (a radioactive form of hydrogen). If growth were in progress, the compound would be absorbed. After an extraction process, readings with a radiation counter or detector can measure whether a cell has been halted or not in its life cycle.

Prior to identification of the chemical inhibitor, it had been thought that normal cells stopped dividing and growing when they reached high densities because some necessary ingredient in the nutrient broth had been depleted, Dr. Fisher said. This phenomena, known as "contact inhibition of replication" has been observed for a number of years by scientists and was the starting point for the current URI study which began five years ago. Dr. Fisher and Dr. Yeh reported on a preliminary phase of their work in *Science* (February 3, 1967).

Various aspects of the research have been sup-

ported by the National Cancer Institute, the American Cancer Society, the National Science Foundation, and the Atomic Energy Commission. In addition, a number of post-doctoral students from Japan and regular graduate students have made contributions to the work.

Recipient of bachelor of science and master of science degrees from the University of Michigan, Dr. Fisher holds the Ph.D. in biophysics from the University of Colorado where he also served as an assistant professor.

UMC Student Gets SK&F Fellowship

Thad Fulton Waites, a junior at the University of Mississippi School of Medicine, has been awarded a $1,416 fellowship which will permit him to assist for 10 weeks this summer at a mission hospital in Indonesia.



Thad Waites

Waites, the son of Mrs. Ottis Waites, of 605 Turner St., Waynesboro, Miss., and the late Mr. Waites, is one of 31 American medical students selected to receive Smith Kline & French Foreign Fellowship from the Association of American Medical Colleges. The fellowships are supported by a grant from the Philadelphia manufacturer of prescription medicines and other health-related products.

Waites is scheduled to leave early in June for Kediri Baptist Hospital in Kediri, Indonesia. He will be supervised by Dr. C. W. Applewhite, administrator and chief of surgery.

The hospital is located in the central part of East Java which has a population of more than one million. It is a relatively poor agricultural area with sugar cane as its main product.

While he is there, Waites will take part in all of the work at the hospital, assisting with rounds, helping in clinics and in surgery, as well as performing some night duty.

Waites completed his pre-medical studies at Mississippi College where he was on the Dean's List and instructed in the zoology laboratories. He was president of his junior class in college and managing editor of the newspaper. Currently he is vice president of the Student Council and a member of the Student Curriculum Study Committee.

Now entering its tenth year, the Smith Kline & French Foreign Fellowships program was established to permit American medical students to widen their medical horizons in cultures different from their own.

In the past nine years, 277 Fellows representing 80 medical schools have served in 52 countries of Africa, Asia, Latin America and Oceania.

Solid Waste Program Is Funded for SBH

The State Board of Health now has funds for a statewide survey of the growing solid-waste problem, Dr. H. B. Cottrell, state health officer, has announced.

He said some 100 local sanitarians will be called to four regional meetings and given instructions on procedures to follow in a survey expected to begin April 1.

Dr. Cottrell said every incorporated municipality in the state—some 280 in all—will be surveyed as to type and quantity of solid waste and cost of storage, collection and disposal.

"At the close of the study," said Dr. Cottrell, "we hope federal funds will be available for implementation of study findings, particularly for building suitable solid-waste disposal facilities."

He made the statement in announcing action by the United States Public Health Service in approving $31,000 for the Mississippi study to be matched by a like amount from the State Board of Health.

"The grant covers one year, beginning March 1," said Dr. Cottrell, "and we hope that we will get grants for two additional years, since our plans are predicated upon a three-year study.

Dr. Cottrell said the study will be coordinated by the Division of Sanitary Engineering, State Board of Health, and Joe Brown, division director, said V. T. Hawkins, of that division, will be director of the project.

Hawkins said dates will be set soon for meetings in April in Jackson, Greenwood, Hattiesburg and Tupelo, at which time county sanitarians of the State Board of Health will be briefed.

"They will interview city sanitary department officials," said Hawkins, "to determine the type and quantity of their solid waste, including seasonal variations, and the cost of its collection,

storage and disposal. Solid waste also will be evaluated in each municipality on the basis of public health problems created, air and water pollution problems resulting, and enforcement of standards by the municipality."

He said first municipalities to be surveyed will be selected later, depending upon the availability of the county sanitarians, who will work with Hawkins and others from the State Board of Health office in Jackson.

He said the survey would take about two years and recommendations will be made on the basis of findings evaluated toward the end of the proposed three-year period.

"The survey is designed," said Brown, "to find out what the actual conditions are in the various municipalities, insofar as the handling of solid waste is concerned. We'll want to know about frequency of collections, ordinances regarding storage, whether or not a municipality has the right kind of collection vehicles, how they dispose of solid waste and so forth."

Brown and Hawkins pointed out that the problem is caused by the great variety of packaging materials competing on store shelves to attract the eye of the housewife and designed for easy throw-away.

"Much of this material," said Brown, "is difficult to burn, and much of it creates toxic gases and unpleasant odor when it is burned on an open dump, thus creating air-pollution problems. Smaller municipalities can utilize sanitary land fills. But larger cities—because of the quantities involved—may find it more feasible to use enclosed incinerators. If so, it is important that these must be properly designed.

"We want to find out from our study," said Brown, "just which method of disposal will be best. It may vary from one municipality to another. If large costs are involved, several municipalities may want to join together to build one facility."

Arrhythmias Testing Unit Is Available

A four panel table-top unit for physicians to test their ability in the diagnosis and treatment of arrhythmias, has been prepared by the American Heart Association's Committee on Medical Education.

Each of the panels illustrate a medical case, with X-rays and electrocardiograms correlated to the written case history. After studying these, and pertinent laboratory data illustrated on the panels, the physician answers multiple choice questions relative to each case.

The unit is intended for use at local or state medical meetings, as teaching exercises for medical students and house officers, and at hospital staff meetings. It may be obtained on a loan or purchase basis through local Heart Associations or the AHA National Office, 44 E. 23rd St., New York, N. Y. 10010.

AAGP-PHS Cancer Survey Is Success

One million American women have been tested for cancer of the cervix at the end of the first four years of the joint program conducted by the American Academy of General Practice and sponsored by the U. S. Public Health Service. By the end of 1968, more than 5,000 AAGP members in 40 states had participated in the project.



Examining a computer printout of findings in the AAGP-USPHS cervical cancer detection program are, from the left, Drs. Lawrence E. Leigh, Maynard I. Shapiro, both representing AAGP, William L. Ross, and Charles W. Pemberton, both of USPHS.

The program has turned up about 2,000 cases of cervical cancer and some 10,000 patients with suspicious smears who required follow-up examination.

An integral part of the office detection program is the relay of each individual test result to the USPHS Cancer Control Program Branch at Washington. Reports are processed by computer for evaluation in relation to the total and growing sample.

AAGP and USPHS spokesmen said that it is significant that from among the one million women examined, one-third were experiencing the examination for the first time for a disease which kills 14,000 American women annually. The spokesmen said that "it is conceivable that cervical cancer could be virtually eliminated as a cause of death if every woman in the nation were given semiannual or at least an annual examination."

Lilly Reports on Cancer Research

Scientists of Eli Lilly have reported two developments of interest to cancer researchers: the crystallization of L-asparaginase, the first enzyme to be found useful against cancer, and the discovery of a "new lead" in the treatment of experimental solid tumors.

In a paper read before the American Association for Cancer Research, Dr. Peter P. K. Ho, biochemist, disclosed the development of a method for producing L-asparaginase for the first time in its pure crystalline form. Although asparaginase has shown promise in the treatment of leukemias, its clinical evaluation has been hampered in this country and abroad by a shortage of pure material.

In a later session, Dr. Martin J. Sweeney, biochemist, read a paper on mycophenolic acid, which in oral and injectable forms has demonstrated broad-spectrum activity against solid tumors in mice and rats, significantly inhibiting growth of nine of eleven types of solid tumors. A relatively nontoxic substance obtained from a penicillium mold, mycophenolic acid demonstrated marked inhibition of a lymphosarcoma in mice even when treatment was delayed six days after the implanting of the tumor, Dr. Sweeney noted.

The clinical study of this agent is in its preliminary phase, and no results are yet available, he said.

Dr. Sweeney pointed out that the animal body's response to mycophenolic acid may be unique for an anticancer drug. After its administration, the drug apparently is rapidly converted into an inactive form. The cells of a number of solid tu-



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mors, however, produce an enzyme which converts the acid back to its active form. The action appears to be quite specific—only those cells capable of producing the enzyme are sensitive to the action of mycophenolic acid.

This may explain a phenomenon that at first puzzled the Lilly scientists: The drug had little or no effect on leukemias. Most broad-spectrum cancer agents are active against them. The apparent answer is that leukemic cells do not produce the activating enzyme.

Dr. Sweeney said that a good correlation was found between such drug sensitivity and enzyme activity in eleven of fourteen tumors. If this correlation exists for human tumors, he said, it may be possible to predict clinical efficacy by measuring enzyme activity in a biopsy specimen.

L-asparaginase is extracted from a bacterium *(E. coli),* which is a normal inhabitant of the intestinal colon. Asparaginase acts against leukemia cells by depriving them of an essential amino acid, asparagine. Sensitive malignant cells cannot make the asparagine they need, while normal cells are unaffected because they can produce their own. Thus, L-asparaginase takes advantage of the only qualitative difference yet found between normal and malignant cells.

So far it has been assumed that toxicity associated with partially purified L-asparaginase preparations may be related to contaminants from the bacterial source, such as endotoxins. The crystalline material, Dr. Ho said, is apparently free of contaminants. Very large doses have not produced fever in animals, which is a common side effect of partially purified L-asparaginase. Studies are now under way in the Lilly Research Laboratories to determine the toxicity of the pure enzyme.

So far, L-asparaginase appears to have limited usefulness, with only a small number of the total leukemia cases in the United States thought to be candidates for treatment.

Studies by Dr. Ho and other Lilly associates demonstrated activity against a variety of experimental animal tumors.

The Lilly cancer developments are the latest in an eleven-year research program which has produced a number of antitumor agents, including drugs for generalized Hodgkin's disease, childhood leukemias, breast cancer, and other malignancies.

Mrs. Chenault Is Auxiliary Speaker

Mrs. John M. Chenault of Decatur, Ala., president-elect of the Woman's Auxiliary to the American Medical Association, will appear as principal guest speaker at the 46th Annual Session of the Mississippi Auxiliary. This was the announcement of Mrs. Paul B. Brumby of Lexington, state president.



Mrs. Chenault

Mrs. Chenault will address the ladies' luncheon, highlight occasion on May 13 during the Biloxi meeting. The luncheon theme is "Opening New Doors for Doctors' Wives."

Auxiliary officials said that Dr. Chenault, a member of the AMA Board of Trustees, will accompany Mrs. Chenault. He will visit the 101st Annual Session of the state medical association.

Mrs. Chenault is a graduate of the University of Alabama and has been a national director, the historian, and first vice president of the AMA Auxiliary. In Alabama where she has been active in Auxiliary work since 1946, Mrs. Chenault has served twice as president of her local unit and as state president. She has held many other key posts, and she is active in civic, cultural, and church activities in Decatur. She and Dr. Chenault have five children.

Pender Portrait Goes to Hospital

A portrait of the late Dr. C. A. Pender of Kosciusko has been presented by his family to the Montfort Jones Memorial Hospital. Dr. Pender was a charter member of the medical staff of the institution.

Participating in the ceremonies were Dr. John W. Pender of Palo Alto, Calif., a son of the honored physician, Mrs. Pender, Dr. Coleman Pickle, incumbent chief of staff of the hospital, and administrator D. B. Watson.

Dr. Pender practiced at Kosciusko from 1920 until his death in 1962.

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College of Surgeons Names New Director

Dr. C. Rollin Hanlon of St. Louis, professor of surgery and chairman of the Department of Surgery at St. Louis University School of Medicine, has been named director-elect of the American College of Surgeons. His election has been announced by the ACS Board of Regents.



Dr. Hanlon

Dr. Hanlon will assume the directorship of the College soon after the close of the College's 1969 Clinical Congress, to be held in San Francisco Oct. 6-10. He will succeed Dr. John Paul North, who had informed the Board of Regents two years ago that he intended to retire in 1969. Dr. North has been director of the College since 1961.

Born in Baltimore, Md., in 1915, Dr. Hanlon received his Bachelor of Arts degree from Loyola College, Baltimore, in 1934, and his M.D. degree from Johns Hopkins University School of Medicine, Baltimore, in 1938. He interned in surgery at the Johns Hopkins Hospital followed by a year as the W. S. Halsted Fellow in Surgery. From 1940 to 1944 he served as exchange Fellow in Surgery at the University of California and as a resident in surgery at the Cincinnati General Hospital with Dr. Mont R. Reid.

After interruping his residency to serve in the Navy overseas, Dr. Hanlon returned to Johns Hopkins as instructor and resident in surgery in 1946. He became associate professor of surgery in 1950 before assuming his present position at St. Louis University in 1950, when he also became surgeon-in-chief of the St. Louis University Hospitals.

A fellow of the American College of Surgeons since 1953, and a member of the College's policy-making Board of Regents since 1967, Dr. Hanlon was a governor (state representative) of the College from 1957-1959, and a member and vice-chairman of its Committee on The Forum on Fundamental Surgical Problems from 1960-1965. Now a member of the College's Cardiovascular Committee, he was elected chairman of the Committee on Graduate Education in 1967.

Dr. Hanlon also heads a committee of the Board of Regents charged with the establishment at College headquarters of an international registry of human transplantation cases, a joint project of the National Institutes of Health and the College.

A founding member of the Board of Thoracic Surgery, Dr. Hanlon was a member of the American Board of Surgery from 1961 to 1967, serving as Chairman of the Board in 1966-67. He is a member of the Central, Western and Southern Surgical Associations, and currently secretary of the American Surgical Association. He served as treasurer of the American Association for Thoracic Surgery and as secretary and president of the St. Louis Surgical Society, and of the North American chapter of the International Cardiovascular Society. He is currently president of the Society for Clinical Surgery and the Society for Vascular Surgery.

Dr. Hanlon has published extensively on scientific and educational subjects. He is a member of the University Club and first vice president of the Serra Club of St. Louis. In 1949 he was married to Dr. Margaret M. Hammond; they have eight children.

The American College of Surgeons is a voluntary professional association of surgeons numbering more than 30,000 Fellows in the United States and Canada, and some 90 foreign countries. It was founded in 1913 to improve the care of the surgical patient. Dr. Hanlon will be the College's fifth director.

AAGP Will Help Organize Residencies

The American Academy of General Practice will pay a consulting fee and expenses of qualified consultants to help hospitals and medical schools plan and set up graduate and undergraduate training programs in family practice, according to Dr. R. Neil Chisholm, chairman of the Academy's Commission on Education.

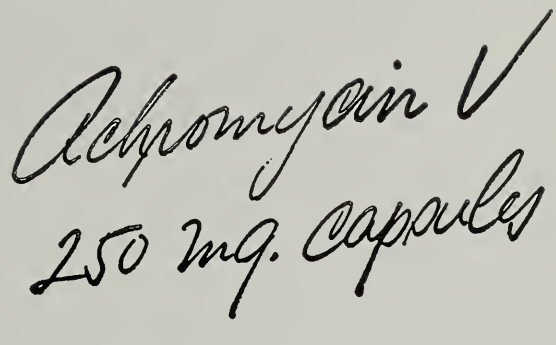
The program is designed to aid in the rapid establishment of approved residency training programs geared to produce candidates for the newly-created specialty of family practice, Dr. Chisholm said. The Council on Medical Education of

the American Medical Association and the Advisory Board for Medical Specialties approved a primary certifying board in family practice Feb. 8, 1969.

Dr. Chisholm added that the consultant will be reimbursed for actual expenses and paid an honorarium of $100 for each day of consultation, with a limit of two days for each visit.

"The AAGP Board approved a sum of up to $50,000 for this program in 1969," he said. "This kind of money means that we can get our qualified consultants out into the field right away, and they can afford to spend the time necessary to get these programs planned and going. Also, having these funds available will help us to obtain more consultants quickly and start moving them into the pipeline."

Dr. Chisholm said the sum approved represented a large number of visits and was evidence of the fact "that the AAGP means business on these family practice programs." He added that educators and practicing physicians who feel they would be qualified, and would like to do this kind of work, should contact him through Academy Headquarters, Volker Boulevard at Brookside, Kansas City, Mo. 64112.



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Council Urges Head Start Extension

The Joint Council of National Pediatric Societies has called for the continuation of Head Start programs, and where possible, the extension of Head Start to year-round programs.

Testifying on behalf of the Joint Council, Dr. Hugh C. Thompson of Tucson, Ariz., president of the American Academy of Pediatrics, also urged extending the Head Start program to younger children, while "continuing the emphasis on community and parent participation."

Dr. Thompson appeared today before an ad-hoc task force of the Committee on Education and Labor, U. S. House of Representatives. The task force is meeting to consider H. R. 513, which would extend the Economic Opportunity Act for five years. Present legislation governing the operation of the U. S. Office of Economic Opportunity expires on June 30.

Dr. Thompson stressed the need to place the Head Start program where the concept of local initiative, together with national funding and guidelines for the development of Head Start programs, can be maintained.

He also stated that health care is a vital component of Head Start, and should be coordinated both with the other aspects of Head Start, and with other child health programs.

Dr. Thompson said that this concept is in agreement with the stated position of the Joint Council of National Pediatric Societies "on the need to consolidate and coordinate the diverse federal programs for child health services to insure most efficient utilization of scarce health manpower and limited resources."

In his testimony, Dr. Thompson pointed out that the Head Start program has provided needed services to many children. He also emphasized that Head Start has strengthened the concept that communities, families, and various professionals can and must work together to reach solutions to important social issues.

"Head Start has emphasized the importance of a truly comprehensive approach to meeting the developmental needs of children," Dr. Thompson said. "This vital ingredient of the program must be preserved to provide the balance of educational, nutritional, health and other social issues."

The Joint Council of National Pediatric Societies includes representatives from the American Academy of Pediatrics, the Association of Medical School Pediatric Department Chairmen, the American Pediatric Society, the Association of Teachers of Maternal and Child Health, and the Society for Pediatric Research.

The Council's purpose is to coordinate and express common policies of its constituent societies in matters related to national issues affecting child health.

The American Academy of Pediatrics is currently directing the Medical Consultation Service for Head Start programs throughout the country. Under this service, the AAP provides more than 600 physician consultants from its membership and from other leaders in the field of child health to advise the medical programs of Head Start projects in nearly 2,000 communities throughout the United States.

NIH Prepares Virus-Cancer Book

Studies of the role viruses play in cancer causation are described in a 20-page booklet, "Virus-Cancer Research," issued for the general public by the U. S. Department of Health, Education, and Welfare. It was prepared by the National Cancer Institute, National Institutes of Health, as a general revision of an earlier booklet by the same title.

"Virus-Cancer Research" describes and explains some of the approaches currently being utilized in virus-cancer work. It discusses the nature of viruses, their existence in our modern environment, and their implication in leukemias, lymphomas and solid tumors. The pamphlet also describes current research efforts to find a possible virus-cancer path from animals to man, and reports on the prospects for prevention and therapy of viral diseases.

According to the pamphlet, viruses are responsible for such a variety of cancer in laboratory animals that it would be surprising if they did not cause some type of cancer in man. By making use of tissue culture, electron microscopy and many other sophisticated laboratory techniques, researchers can now hope to come up with answers to the questions posed by this evidence. If a virus-cancer link in humans can be demonstrated, it may pave the way for the development of new preventive measures and may open up new areas in the treatment of cancer.

Dr. Hardy Receives Double Honors

Dr. James D. Hardy of Jackson, professor and chairman of the department of surgery at the University Medical Center, was honored by two state organizations last month for his pioneering research in transplant procedures.

A special award was bestowed on Dr. Hardy by the Mississippi Economic Council at its 20th Annual Convention at Jackson. The Jackson Chapter of Hadassah conferred the organization's Humanitarian Award on him in ceremonies earlier in the month.

One of the international activities of Hadassah is sponsorship of a medical school, dental school, and teaching hospital in Israel which is open to all creeds and races.

Dr. Hardy has previously received the University of Mississippi-First Federal Foundation "Missy" Award in 1968 for his work at UMC.

Pfizer Will Give 101 Scholarships

The Medical Department of Pfizer Laboratories Division has announced that it will make available $1,000 medical school scholarships to each of the country's 101 medical schools, bringing to $740,000 the total contributed since the program was launched in 1962.

Selection of the recipient of the scholarship may be on the basis of scholastic record, financial need or both. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the medical schools in the United States. The scholarships are administered solely by the dean of each medical school, or by a committee established by him.

Since their inception in 1962, the Pfizer scholarships have been accepted in each of the medical schools in the United States.

In the 1968-69 school year, 98 medical schools in the 50 states, the District of Columbia and Puerto Rico received scholarship funds. Students from more than 31 states received scholarships in 1968. Of these, ten were from New York State, six from California, five from Pennsylvania and four from Texas. Other states with more than one scholarship recipient include Virginia, Kentucky, Ohio, Florida, Kansas, Missouri and Iowa with two each; Minnesota, Indiana, New Jersey, each with three.

In addition to the medical school scholarship program, Pfizer has also provided the American Medical Association's Educational and Research Foundation with $480,000 in the past seven years. These Pfizer grants have provided $6,000,000 credit for loans to medical students, interns and residents during this period. Recipients of the loans are in training in medical schools and hospitals throughout the country.

Physician Is Unhurt in Aircraft Mishap

Dr. Verner S. Holmes of McComb escaped serious injury when the aircraft he was flying splashed down in Lake Ponchartrain. Dr. Holmes and a passenger, Johnny Wynne of Jackson, were rescued by a helicopter moments after the mishap.

Accounts said that the aircraft, an "S" model Beechcraft Bonanza, overshot runway 31 at the New Orleans Lakefront Airport in foggy conditions, failing to regain altitude under power. Dr. Holmes and Wynne were plucked off the wing of the semi-submerged plane by helicopter pilot Frank Bruce of the Chevron Oil Corp. who was at the airport at the time of the accident.

The Bonanza sank 75 yards off the east seawall of the airport immediately after the rescue. The only injury reported was a finger laceration sustained by Dr. Holmes.

The well-known McComb otolaryngologist is a member of the Board of Trustees of Institutions of Higher Learning and has recently retired as president of the board.

UMC Contracts Building Addition

Ground was broken for a $486,500, two-floor addition to the University of Mississippi School of Nursing Building on the Jackson Medical Center campus on March 3.

Financed by state revenues and federal matching funds, the new wing will adjoin the present structure to the north and house additional classrooms, faculty offices and conference rooms.

The Jackson firm of Brumfield and Craig is architect for the project with Becknell Construction Company as general contractor. Completion is set for early 1970.

NIH Studies Cancer in Nuns

A study of cancer deaths among Catholic nuns made by the NIH National Cancer Institute shows that these women have a lower death rate from malignant disease in their earlier years, but an appreciably higher rate in later life compared with the general female population.

Results of the study, which covered 31,658 white nuns belonging to 41 different orders in the United States from 1900 to 1954 and compared them with the white female population, were published in the March issue of the *Journal of the National Cancer Institute*. The work was done by Dr. Joseph F. Fraumeni, Jr., Dr. J. William Lloyd, Elizabeth M. Smith and Joseph K. Wagoner of the Institute's Epidemiology Branch.

The study revealed a striking increase in breast cancer among nuns after age 39. This is in line with earlier observations that single women experience substantially higher rates of breast cancer than married women, and that the differential increases with advancing age. The nuns also showed a reduced risk at the time of menopause, confirming an earlier investigation of unmarried women by National Cancer Institute scientists.

Like other unmarried women, the nuns showed a low rate of cancer of the cervix and a high rate of cancer of the corpus of the uterus and the ovary. An increased risk of uterine cervical cancer for married women seems related to exposure to an environmental agent, possibly a virus, during sexual intercourse, according to other studies. A reduced risk of cancer of the uterine corpus, and the ovary among married women is attributed to hormonal changes resulting from pregnancy.

Central Hears Program on Blood

Dr. James B. Hartney of Chicago, director of laboratories at St. Ann's Hospital, appeared as principal speaker at the recent meeting of the Central Medical Society at Jackson, largest component of the state medical association. His subject was "Blood Assurance Plans—An Answer to Blood Shortages."

The program, devoted to solving problems of an adequate blood supply for the society's area, also featured a panel discussion moderated by Dr. Warren N. Bell. Participants were Drs. Kenneth M. Heard, Roland Sampson, and William B. Wilson. Dr. Heard is chairman of the Committee on Blood and Blood Banking of the state medical association. Dr. Hartney is a member of the AMA Council on Blood.

Society spokesmen said that the presentation was timely and response from the society membership was excellent.

Pastoral Institute Is Held at Jackson

The 9th Annual Institute for Pastoral Care, conducted at Jackson by the Mississippi Baptist Hospital and the Hinds-Madison Baptist Association, featured a theme of "Alcoholism and Pastoral Care" last month.

Featured speakers included Dr. William E. Lotterhos of Jackson, a former president of the hospital staff and incumbent speaker of the state medical association's House of Delegates. Also appearing was the Rev. Dr. C. Roy Woodruff, director of pastoral care and education at Bryce Hospital in Tuscaloosa. Rev. Dr. Dudley Wilson of Jackson, pastor of the Northminster Baptist Church, addressed the institute.

Coordinating program activities was Rev. Dr. H. Gordon Shamburger of Jackson, chaplain of the Baptist Hospital. The institute was conducted in the auditorium of the Gilfoy School of Nursing.

Med School Faculty Now Totals 130

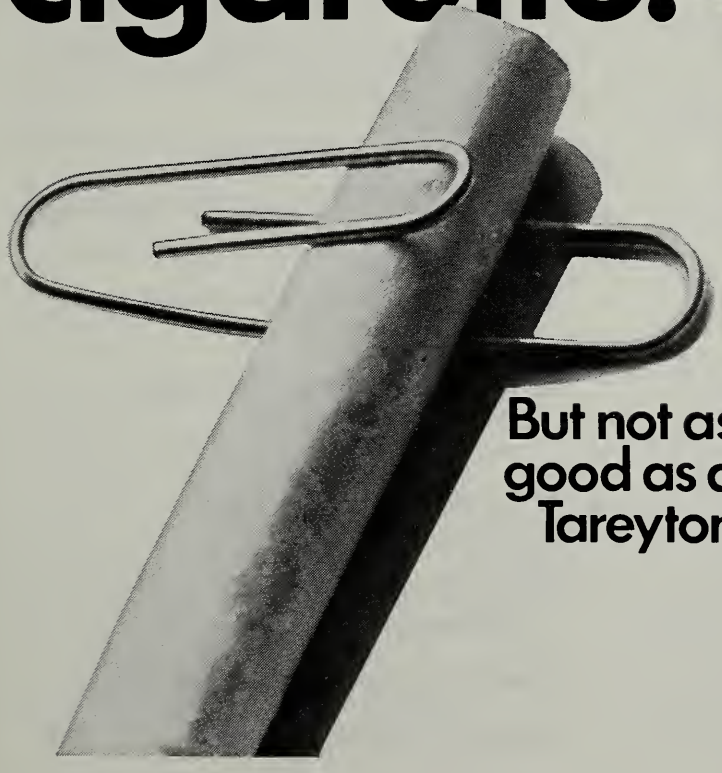
Three new appointments this spring have brought the number of full-time University of Mississippi School of Medicine faculty to a total of 130.

Added at the rank of assistant professor, effective July 1, is Dr. Dale Jeanette Pullen. Dr. Pullen earned the M.D. degree at Tulane and comes to the Medical Center from a postdoctoral fellowship at Tennessee.

Instructors joining the faculty are Dr. David J. Davis, surgery and Miss Martha Beul Lyle, surgery (audiology). Dr. Davis earned his M.D. degree from the University of Pennsylvania and did internship at University Medical Center. Miss Lyle holds the A.B. degree from Montclair State University and the M.Ed. from the University of Virginia.

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CONTENTS

ORIGINAL PAPERS

UMC Stroke Unit: Review of the First 100 Cases **237** A. F. Haerer, M.D.; R. R. Smith, M.D.; and R. D. Currier, M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXVI: Intestinal Amebiasis **242** Nancy R. Burrow, M.D.

Blood Assurance Plans: An Answer to Blood Shortages **244** James B. Hartney, M.D.

Clinicopathological Conference XCIV **249** Mississippi Baptist Hospital, Jackson

EDITORIALS

From Flexner to Millis: Six Decades of Miracles **257** Poverty of Plenty

Home Health Dilemma: Underutilization **260** Patient Benefit

Medicaid's Unholy Image **261** Few Abuses, Much Furor

Kudos for the College **261** Cancer Programs

THIS MONTH

The President Speaking **256** Wanted!

Medical Organization **265** 101st Annual Session

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AMA Announces Audio News Journal

In a major communications effort aimed at enabling physicians to keep abreast of significant medical developments which are part of today's "information explosion," the American Medical Association introduced *Audio News Journal,* a new concept in medical reporting, in January.

Called the "living voice of medicine," *Audio News Journal* is a once-a-month, 65-minute tape recording highlighting current medical events throughout the world. Initial charter subscribers received their first tape in January.

Because demands on the physician's time are so great, the recorded informational service was envisioned as a practical means of permitting him to keep pace with medical developments by playing all or segments of a recording during "idle" or "unproductive" moments at home, in the office or in the car.

All coverage provided through the recorded news format of *Audio News Journal* is live. The informational service is not intended as a medium to provide verbal reporting of scientific papers or condensation of published medical news.

A wide variety of subject matter is covered on the tapes, but emphasis will be on-the-scene coverage of major medical meetings, new developments in the health field and interviews with health professionals and public figures on political, social and economic aspects of medicine.

Serving as anchorman for the news programs is Raymond Burr, better known as television's "Ironside" or "Perry Mason." On-the-spot reporting is handled by a team of correspondents.

Subscribers may choose from three types of tapes which are offered—eight-track stereo, cassette or reel-to-reel. Annual subscription price for the informational service is $72 for physicians in the U. S., its possessions, Canada and Mexico and $90 in all other countries. Charter subscribers are being offered 15 months of service for the price of 12. Orders should be directed to the AMA Circulation and Records Department, 535 N. Dearborn, Chicago, Ill. 60610.

The AMA's Board of Trustees approved the concept last fall following more than a year of study by members of the AMA staff. A market-

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ing study, including a questionnaire sent to physicians, indicated high interest in such a service.

Introduction of *Audio News Journal* marks the first time that a professional association has developed a recorded informational service of this type for its total membership.

The informational service was demonstrated to the profession at the AMA's Clinical Convention in Miami last December, and a mailing describing the new service was sent to all AMA members in January.

NIH Sets Artificial Heart Institute

June 9 is kickoff date for a five-day Artificial Heart Program Conference sponsored by the National Heart Institute of the National Institutes of Health.

The Conference, to be held in the Regency Room of the Shoreham Hotel, Washington, D. C., will feature 90 scientific presentations describing current progress toward the development of circulatory assist devices and total heart replacements under research contracts awarded by the NHI Artificial Heart Program. The sessions will be open to the scientific community and to the press.

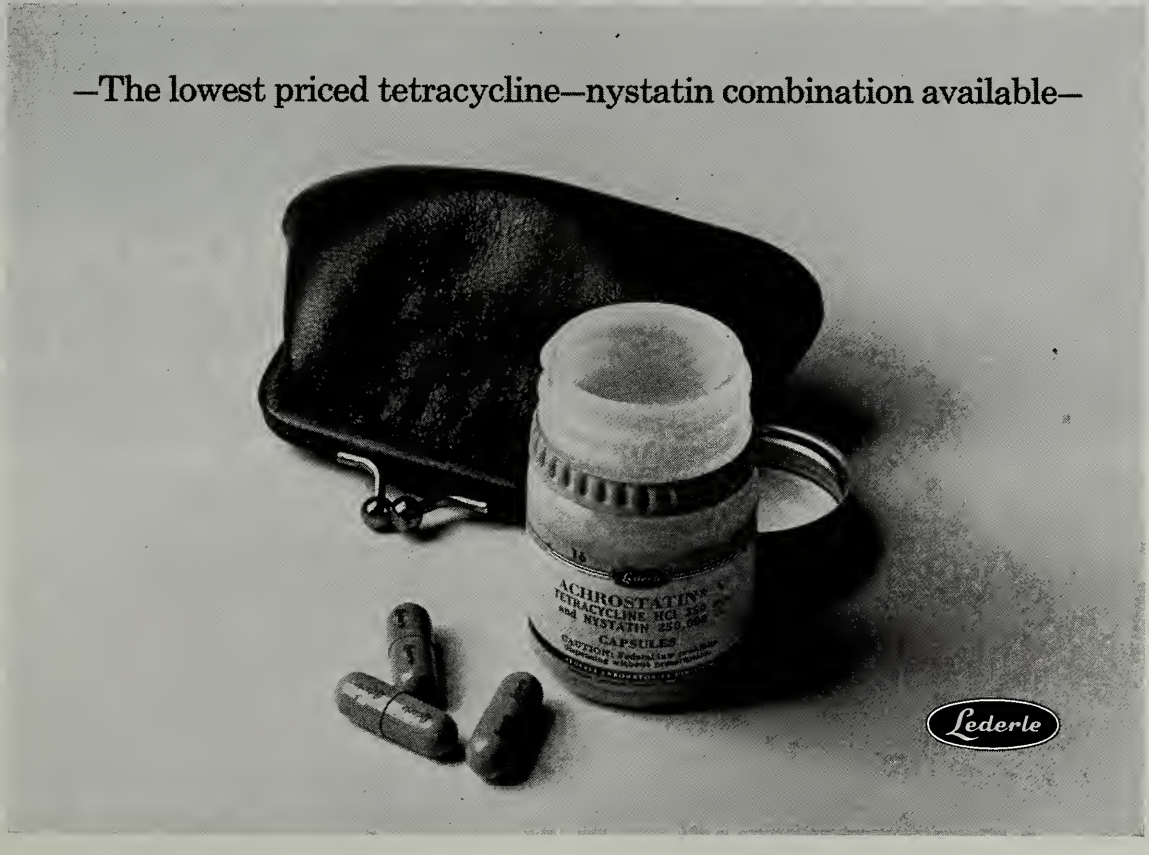
The Monday sessions will highlight progress in the development of blood and tissue-compatible materials and the results of *in vitro* and animal studies evaluating the effects of various materials on blood.

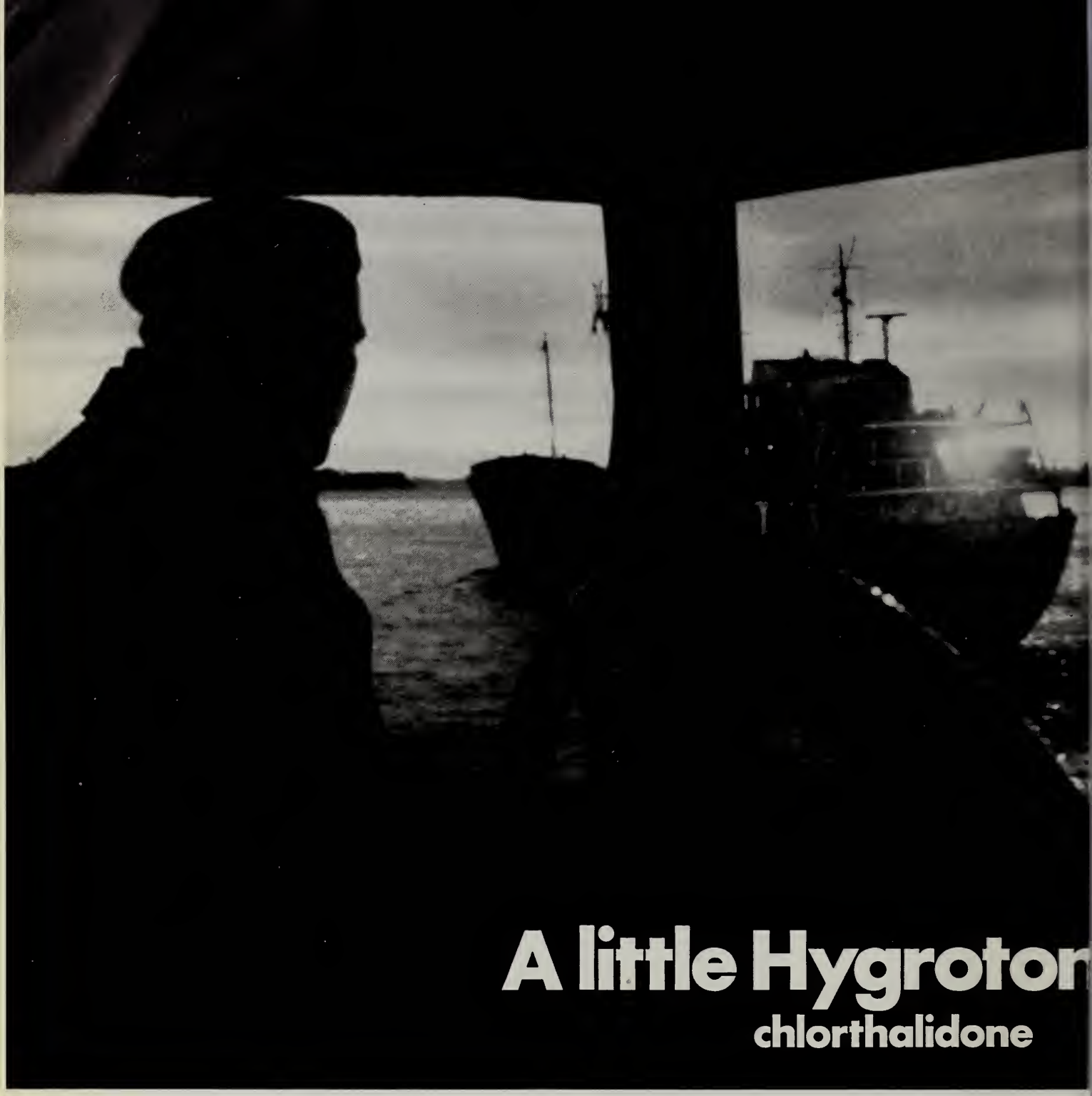
On Tuesday, June 10, the sessions will include studies on bloodflow through pumps and valves, indices of heart function useful in the regulation of heart-assist devices, and the development of improved oxygenators for heart-lung machines or other medical uses.

On Wednesday, June 11, circulatory assist devices and the physiological effects on these devices in animals will be covered.

The Thursday, June 12 sessions will deal with instrumentation applicable to the development, evaluation, and use of artificial heart and circulatory assist devices; through-the-chest leads for powering and controlling implanted devices; biological fuel cells as a potential implantable power source; and the physiological effects of heat generated by the implanted power drive of artificial hearts.

The Friday, June 13 sessions will cover recent developments and problems in the area of implantable energy systems.





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Medical Assistants Offered Loans

Any qualified person wishing to pursue a career as a medical assistant may apply for a scholarship loan through the Maxine Williams Scholarship Fund, sponsored by the American Association of Medical Assistants' Endowment. This foundation was established in October 1968 to administer the scholarship fund.

Participants in the loan program may borrow up to $300 for their education. As a service to the profession, AAMA assumes all administrative costs so there is no interest rate on the loan. If the recipient spends a minimum of two years in the medical assisting field, the loan becomes an outright scholarship, and no repayment is required.

The fund, named in honor of Miss Maxine Williams, AAMA's first president, is supported entirely by private donations from state medical assistant associations as well as local chapters. Contributions are tax deductible as an educational expense.

To be eligible for a loan, one must be a high school graduate who wishes to take formal training in medical assisting. At the present time, AAMA is working with the American Medical Association on an approval program, eventually leading to a standard medical assisting curriculum. The suggested two-year program recommends both administrative and clinical training for an Associate Arts degree at an accredited community or junior college.

Application blanks and information about the Scholarship Loan Fund may be obtained from American Association of Medical Assistants, 200 East Ohio Street, Chicago, Illinois 60611.

Second National Coronary Care Conference Set

A 2nd National Conference on Coronary Care Units, designed as a forum for physicians and nurses who work in these units, is set for June 18-20, 1969, in the Denver Hilton Hotel, Denver, Colorado. Its theme is "Drug Therapy in Coronary Care—1969."

The Conference is co-sponsored by the American Heart Association, American College of Cardiology and the Heart Disease and Stroke Control Program of the United States Public Health Service. The Colorado Heart Association is cooperating in the program.

A preliminary program "Patterns and Issues in Coronary Care Training," planned for Wednes-

day evening, June 18, will include teaching methods for physicians and nurses in coronary care units in large metropolitan or small community hospitals. The results of these training courses and a Public Health Service evaluation of 12 training programs for nurses will also be covered.

Dr. Arnold M. Weissler of Columbus, Ohio, will chair the June 19 program. This group will be welcomed by Drs. Walter B. Frommeyer, Jr. of Birmingham, Ala., and B. L. Martz of Indianapolis, Ind., presidents respectively of the American Heart Association and American College of Cardiology, and Samuel M. Fox, III, Chief, Heart Disease and Stroke Control Program. Dr. James V. Warren, Columbus, Ohio, a past-President of the American Heart Association, will speak on "Coronary Care Units: A New Generation." Talks also will be given by Dr. Bernard Lown of Boston, on "Philosophy of Drug Management in Acute Myocardial Infarction," by Dr. Andrew G. Wallace of Durham, N. C., on "Mechanism of Action of Anti-Arrhythmic Agents," by Dr. Leonard S. Dreifus of Philadelphia, on "Clinical Pharmacology of Anti-Arrhythmic Agents" and by Dr. Harvey M. Solomon of Baltimore, on "Problems in Drug Interaction."

Dr. Hughes W. Day, Kansas City, Kansas, will chair Friday's session. This will include addresses by Dr. John Ross, Jr., San Diego, Cal., on "Problems of Hypotension and Shock Following Acute Myocardial Infarction," by Dr. Leon I. Goldberg, Atlanta, on "Vasoactive and Inotropic Agents in Management of Cardiogenic Shock," and by Dr. H. Jeremy C. Swan, Los Angeles, on "Problems of Heart Failure Following Acute Myocardial Infarction." Drs. Frank I. Marcus, Tucson, Arizona and Walter M. Kirkendall, Iowa City, Iowa, will speak respectively on "Digitalis Therapy" and on "Diuretic Agents." The Conference findings will be summarized by Dr. Arnold M. Weissler of Columbus, Ohio.

The First National Conference on Coronary Care Units was held in 1967 in Washington, D. C.

Miss. Mental Agency Sets Self-Study

Possible new administrative structures for Mississippi's mental health programs will soon be studied by the Mississippi Interagency Commission on Mental Illness and Mental Retardation, according to M.I.C. chairman C. Seth Hudspeth.

He described the study as "part of the continuing effort of the M.I.C. to carry out the planning responsibilities assigned it by the state legislature when the commission was established in July of 1966."



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The M.I.C. consists of the chief executive officers of the state's Board of Mental Institutions, Board of Health, Welfare Department, Department of Education, and Board of Trustees of Institutions of Higher Learning.

Hudspeth said the study represents a new phase of action by the M.I.C. in implementing recommendations growing out of a 1963-65 study of state needs in serving the mentally ill, the mentally retarded, and the alcoholic.

"In the past three years," said Hudspeth, "many of the recommendations from that study have been implemented—especially those calling for action at the regional level in developing regional mental health and mental retardation centers.

"Through the action of regional commissions, regional planning has proven highly successful and is now a well-established avenue for creating local mental health, mental retardation and alcoholism programs. Well over half the state is now represented in regional efforts to plan and support such services.

"In relation to all of these needs," said Hudspeth, "the adequacy of state program administration will be examined. Responsibilities for mental health program administration are currently assigned to the State Board of Health, the Board of Mental Institutions, the Interagency Commission, and elsewhere.

"The interagency approach recommended in the state plan, which resulted from a two-year study by over 200 leaders in Mississippi programs, had as its chief purpose the development of a mental health and mental retardation program in Mississippi through maximum utilization of the personnel of existing agencies.

"The rapid growth of regional programs, however, is placing new and unforeseen demands upon state program administration. In meeting these demands we will evaluate the present structure of split-agency responsibility and, if needed, consider and recommend alternatives to that structure."

Hudspeth added:

"The goal will be to suggest ways to streamline administration rather than complicate it, while maintaining the interagency involvement which has proven so successful in program planning and development."

Hudspeth said the M.I.C. would utilize the services of its two major advisory groups in the current study. These are the mental health program council, chaired by Dr. W. L. Jaquith, and the mental retardation program council, chaired by Dr. Blair Batson. In addition, ad hoc committees will be established as needed.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

UMC Stroke Unit: Review Of the First 100 Cases

A. F. HAERER, M.D.; R. R. SMITH, M.D., and
R. D. CURRIER, M.D.
Jackson, Mississippi

THE PURPOSE of this paper is to consider the problems and benefits which result from the operation of a stroke care demonstration unit. The value of centralized units for the care of the acutely injured, the patients with acute paraplegia, and patients with acute myocardial infarction has been clearly demonstrated in the recent past. The advantages and disadvantages of a central unit for the care of the stroke patient are less clearly defined. Only a few such centers have been established in this country to date. The present review analyzes data concerning the first 100 patients admitted to the Regional Medical Program Demonstration Unit for Stroke Care at the University of Mississippi Medical Center.

Until recently, the University Hospital in Jackson, because of the pressure of bed occupancy for other acute diseases, was traditionally unable to admit patients with "routine" strokes. Stroke patients who were moribund or who had evidence of hemorrhage might be admitted, but the usual patient with an ischemic infarct or a transient ischemic episode could not be admitted for investigation or therapy unless he was under the care of a private physician. Thus, there was a lack of hospitalized patients with strokes and proper care could not be demonstrated to students.

From the Division of Neurology and Department of Neurosurgery, University of Mississippi School of Medicine.

With the support of the Mississippi Regional Medical Program, a four-bed demonstration stroke center was authorized in 1967 at the University Hospital. Space was allocated and an excellent nursing staff recruited. The unit accepted its first patient in October of that year. The expressed purpose of this unit was to demonstrate to medical and nursing students, house officers, postgraduate physicians and nurses, and allied health professionals the presently generally accepted methods of the diagnosis, treatment and rehabilitation of the stroke patient.

Even a small stroke unit can constitute an effective teaching center for a broad spectrum of medical and paramedical personnel, state the authors. It can serve as a diagnostic and therapeutic nucleus in which patients with remediable types of cerebrovascular disease can receive real benefit, they write. They discuss in detail the University of Mississippi Regional Medical Program Stroke Care Demonstration Unit and its first 100 patients.

The operating principle of the Stroke Demonstration Unit was to concentrate attention on those patients with mild or incipient strokes or other

types of cerebral vascular disease for whom effective treatment could be instituted and rehabilitation could be obtained, rather than to provide simply the basic nursing care for terminal or neurologically unsalvageable patients, which might be achieved just as well in a nursing home. This goal was not easily accomplished for a number of reasons. The selection of suitable patients for the unit was difficult because of the great pressure to admit seriously ill patients rather than those who were neurologically salvageable. A four-bed unit cannot even scratch the surface in actually caring for patients with strokes in a state where 13,000 strokes occur annually.

Over a span of 16 months, 100 patients were admitted to the Demonstration Stroke Care Unit. Our experience to date is reviewed at this time in the hope that it will help us and those operating similar units elsewhere to decide how to obtain the greatest benefit from such a teaching unit.

SOCIOECONOMIC STATUS

The great majority of the patients admitted to the Stroke Unit were indigent. However, private patients were also treated. The Regional Medical Program funds did not provide for the total cost of patient care, so each patient still was considered financially responsible for his care as are all patients in this institution. The patients admitted fell into three large groups. Some were admitted directly from outside or through the emergency room because they were seriously ill and needed immediate care. This group of patients had a higher mortality rate and generally were not neurologically salvageable, as shall be seen. The second group were transferred from the regular neurology service or from some other inpatient service, where they had been held temporarily, so that further diagnostic studies, acute care, or occupational and physical therapy could be carried out. The third group were the ideal patient group (in our opinion) and were admitted for evaluation of transient ischemic attacks or for physical and restoration therapy.

TABLE I

GENERAL CHARACTERICS OF 100 PATIENTS IN DEMONSTRATION STROKE UNIT

	Per Cent
Whites	20
Negroes	80
Males	46
Females	54
Ages: 15-39 years	19
40-59 years	37
60 and over	44
Hypertensive by history	51
Diabetic	19

TABLE II

DIAGNOSIS OF 100 PATIENTS IN DEMONSTRATION STROKE UNIT

	Per Cent
Cerebral infarcts ("thrombotic")	61
Cerebral infarcts ("embolic")	4
Intracerebral hemorrhages	11
Ruptured intracranial aneurysms	6
Arteriovenous malformation	1
Miscellaneous, "stroke-like"	14
Transient ischemic attacks	3

The general data dealing with the first 100 patients are summarized in Tables I-VII. There were 80 Negroes and 20 white patients, the disproportion being due in a large measure to the number of Negroes in the low income group. There was a slight preponderance of females over males. The patients ranged in age from 15 to 86 years, but only slightly less than half of the patients were over 60 years of age. Slightly more than half were hypertensive by history and about one-fifth were diabetic.

The types of cerebral vascular disorders are summarized in Table II. Two-thirds were patients with cerebral infarcts, 18 per cent had various hemorrhagic episodes, 3 per cent had transient ischemic attacks and 14 per cent had miscellaneous "stroke-like" syndromes.

DISCHARGE DIAGNOSES

Of the 14 patients presenting with "stroke-like" syndromes, all but one could reasonably have been diagnosed as cerebral vascular disorders. Table III details final diagnoses at the time of discharge.

Table IV summarizes some of the more important diagnostic tests and treatments of these 100 patients. The studies were facilitated by the acquisition of equipment for angiography and brain scanning with the help of funds from the Regional Medical Program. Approximately 80

per cent of the patients were studied by brain scanning techniques, but the results of this will not be summarized at this time.

TABLE III

PATIENTS WITH DIAGNOSES OTHER THAN STROKE—"MISCELLANEOUS" ADMITTED AS PRESUMPTIVE STROKES

Epileptics	3
Brain tumors	4
Multiple sclerosis	1
Pseudotumor	1
Catatonia	1
Spinal cord thromboses	2
Korsakoff's syndrome	1
Myasthenia gravis	1*

* Not presumed to be a stroke.

One-fifth of the patients who had lumbar punctures had evidence of bleeding into the subarachnoid space. Cerebral angiograms were done in 40 per cent of the entire group and were abnormal in two-thirds of those. Eight patients were transferred to the neurosurgical service for operation; 5 of these had lesions in the extracranial large arteries.

TABLE IV

DIAGNOSTIC TESTS AND TREATMENTS OF 100 PATIENTS IN A DEMONSTRATION STROKE UNIT

A. Lumbar Puncture:	
CSF clear and colorless	61%
CSF bloody or xanthochromic	16%
Not done	23%
B. Cerebral Angiograms: Done on 40%	
Normal in 13 patients	
Abnormal in 27 patients	
Findings: 1 carotid completely occluded in 4 patients	
1 carotid partially occluded in 2 patients	
Aneurysm or A-V malformation in 7 patients	
Other abnormalities (clots, tumors, intracranial occlusions) in 14 patients	
C. Operations Done:	
Carotid endarterectomies	3
Carotid explorations	2
Craniotomies	2
V-A shunt	1
Tracheostomies	8
D. Anticoagulation:	
In hospital	4
After discharge	1
Both	6

TABLE V

DISCHARGE FROM HOSPITAL OF 100 PATIENTS IN A DEMONSTRATION STROKE UNIT

	Per Cent
To home	70
To extended care facilities	15
Died in hospital	15

This number of patients who were actually found to have extracranial remediable (operable) arterial disease as cause of their symptoms was surprisingly small. Only 3 patients had carotid endarterectomies. One of these had an excellent result with a normal neurological examination afterward. One had a fair result, but the external carotid re-occluded later, and one patient died postoperatively. Two other patients who had carotid explorations were found not to be amenable to endarterectomy.

TABLE VI

FOLLOW-UP DATA ON 100 PATIENTS FROM A DEMONSTRATION STROKE UNIT
(Longest follow-up—20 months)

Data as of March, 1969

	Per Cent
Patients neurologically normal and working	10
Patients slightly paretic but working	2
Patients ambulatory without aid, not working	18
Patients ambulatory with aid only, not working	21
Patients confined to bed or wheelchair	9
Patients died while in hospital	15
Patients died after discharge	18
No follow-up data	7

Anticoagulants were used in treating a few patients but the series is too small to be able to draw conclusions regarding the benefits of this treatment.

PATIENT FOLLOWUP

Of special interest is the information summarized in Tables V and VI, dealing with the outcome of treatment and the followup of patients admitted to the unit from the time of discharge to 16 months after the unit was opened. Of 100 patients, 70 per cent were discharged to their homes, 15 per cent to extended care facilities and 15 per cent died in the hospital. The patients who died in the hospital were mainly those who were

neurologically unsalvageable at the time of their admission, or were comatose, or had severe intracerebral bleeds, or serious concomitant disease such as heart disease or pneumonia. Several patients died in the hospital from pulmonary emboli and myocardial infarctions.

Of the patients discharged, all but 7 have been followed-up, either in person by the medical staff or by telephone or letter of inquiry through March, 1969. From the total of the 100 patients treated in the Stroke Unit, 10 are at the present time neurologically normal and working, two are working and only slightly paretic, 18 are ambulatory without aid but are not working for various reasons (many of these are above the normal work age). Twenty-one per cent are ambulatory with the aid of canes or other devices and are not working. Many of the latter group are over 65 years old. Nine are confined to a wheelchair or to bed. Eighteen died after discharge from the hospital.

MORTALITY CHARACTERISTICS

Of the 18 that died after discharge, the majority again were patients who were considered neurologically unsalvageable during their admission. This includes those who were either nearly totally paralyzed, severely demented or had bilateral infarctions. Four of the 18 had neurological problems other than cerebrovascular accidents which led to their demise, including several with neoplasms of primary or disseminated nature. Four patients had serious heart disease with their cerebral infarct which was considered a factor in their mortality. Seven of the 18 patients who died after discharge did so in nursing homes, 3 were re-hospitalized, either here or elsewhere, and died on readmission, and 8 died at home. The survival, after discharge from the hospital, of the 18 patients who died ranged from one day (a patient who had a sudden myocardial infarction) to eight months.

TABLE VII

TEACHING FUNCTIONS OF A DEMONSTRATION STROKE UNIT

In one year of operation, the following persons examined or followed patients in this unit:
80 Third year medical student
40 Fourth year medical students
4 Neurology residents
4 Psychiatry residents
2 Neurosurgery residents
15 Out-in-state physicians taking a special stroke course
35 Nursing students
20 Nurses from outstate (special courses)
10 Physical therapy students
In addition, patients were shown to freshman and sophomore medical classes, at various conferences throughout the year (average 2 per week) and to the State on television.

RECOVERY DATA

Thus, slightly more than half of the patients from this heterogeneous and, of necessity, poorly selected group, are now either normal or sufficiently independent so as to be able to take care of their own needs at home. No follow-up data could be obtained on 7 patients.

The teaching functions, considered of primary importance in a demonstration stroke unit, which took place during the period of the first year's operation are summarized in Table VII. A strong attempt was made to expose as many students, physicians and paramedical personnel as possible to the patients for teaching purposes.

There are 13,000 strokes reported yearly in the State of Mississippi. Approximately 80 of these per year can be admitted to the Demonstration Stroke Care Unit in its present facility. Although there has been some misunderstanding by physicians in the state as to the capacity of our Stroke Care Demonstration Unit to handle a greater number of patients, most of the physicians have been quite understanding and tolerant of our inability to admit every stroke patient who presents to the emergency room. An attempt has been made to explain this problem by the Public Information Office of the University Hospital. It is felt that the Stroke Unit has filled its commitment for a teaching center fairly well and has helped to fill an uncomfortable gap in local medical education concerning cerebral vascular disease and its therapy.

COROLLARY BENEFITS

One of the unexpected benefits from the Stroke Unit operation was the discovery of a number of treatable and unusual entities. For example, one patient had Takayasu's disease and made a very nice recovery when he was placed on corticosteroids. In addition, several patients with brain tumors were diagnosed and received palliative therapy.

It is obvious that, due to the pressure from various directions and due to the high prevalence of seriously ill patients with strokes, the patient selection for the Stroke Demonstration Care Unit was not optimal. We did admit patients who had a poor prognosis and for whom we could do no more than could have been done in less specialized units. Our experience to date shows that even a small demonstration stroke care unit can constitute a teaching center for a large and broad spectrum of students and can, in addition, serve as a diagnostic and therapeutic nucleus in which patients with remediable types of cerebrovascular disease can receive real benefit.

A great deal has been learned from the operation of this unit and from the first 100 patients. Plans for the future include greater effort to concentrate on the admission of neurologically salvageable patients and especially those with transient ischemic episodes. We are thus planning to expand the unit slightly. It is proposed that two beds be added to the present unit which will be reserved for short-term rapid diagnostic evaluation of patients with transient ischemia with subsequent rapid discharge to the referring physician if no surgically or medically treatable condition is found.

Also, a reverse telephone WATS line is being instituted which will permit easy consultation for physicians from throughout the state concerning patients with any type of cerebrovascular disorder and thus provide help to the local physician in the care of those patients and help us in the selection of those patients for admission to this specialized unit.

SUMMARY

The problems and benefits of the first stroke care demonstration unit established under the Regional Medical Program in the United States are reviewed. Even a small stroke unit can constitute an effective teaching center for a broad spectrum of medical and paramedical personnel. It can serve as a diagnostic and therapeutic nucleus in which patients with remediable types of cerebrovascular disease can receive real benefit. Experience to date points out the importance of concentrating efforts on the neurologically salvageable stroke patient in such a unit. Plans and modifications for the future are outlined. ★★★

2500 N. State St. (39216)

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RUSH TO JUDGMENT

Six of us, all mature M.D.'s, were playing golf together before an evening medical meeting. We were being overtaken by two younger golfers. Suddenly one of our group was hit in the head by an oncoming ball. The pain was intense, and all five of us gathered around our injured colleague solicitously.

Just then the young man who'd hit the drive pushed his way through the group, shouting, "Gangway! I'm a medical student. Let me through so I can examine this man!"

—Charles Henderson, M.D.

Radiologic Seminar LXXXVI: Intestinal Amebiasis

NANCY R. BURROW, M.D.
Brandon, Mississippi

THE DIAGNOSIS of intestinal amebiasis depends almost entirely upon demonstration of *Entamoeba histolytica* in the stools. The areas of bowel most frequently involved are the cecum, appendix, ascending colon and rectosigmoid. The proximal areas are more commonly involved.[1] The organism produces infiltrations in the submucosa with the formation of nodules which eventually break down forming ulcerations. These ulcerations are usually separated by normal mucosa, but as the disease progresses, they become confluent. The ulcers undermine on their edges and may become connected by sinuses beneath the mucosa.[2]

The subacute and chronic stages lead to the formation of scar tissue which can produce annular constrictions, saccular dilatation and diffuse thickening of the bowel wall.

The amebic granuloma or ameboma is an infrequent manifestation of the disease. It is an indurated sausage-shaped tumor which can occur in the cecum of rectosigmoid and closely resembles a carcinoma in the gross features.

Clinically, patients with this disease have vague abdominal complaints, occasional constipation or constipation alternating with diarrhea. The symptoms may be referrable to the liver as liver abscesses occur in 5 per cent of the cases. If liver puncture is performed and a chocolate-colored pus is obtained, amebic disease is a good possibility.

Radiographically, there may be no manifestations early in amebic disease of the colon. As the disease progresses, however, pronounced segmenting haustrations may be observed in the cecum and ascending colon. Later as a result of cicatricial processes, cecal deformity may result. According to some observers, cecal deformity occurs in approximately one-third of the cases with positive stools. The deformity is one of concentric narrowing and shortening with loss of haustral indentation. The cecum often is cone-shaped and tender to palpation. In the rectosigmoid portion of the colon, stenotic narrowing is the rule and is hard to differentiate from other lesions, especially carcinoma.

Roentgen findings of liver involvement are alteration in the contour of the diaphragm, enlarged liver, associated plate-like atelectasis or even pleural effusion at the right lung base. Another more recently developed diagnostic aid for liver involvement is the liver scan. This study is performed with radioactive isotopes given intra-



Figure 1. Barium enema study demonstrating conical deformity of cecum as outlined by arrows.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Hinds General Hospital. (Dr. Burrow is now at the Rankin County General Hospital.)

venously which are concentrated in cells of the normal liver. The abscess cavity will not accumulate the isotope, resulting in an area of relatively decreased radioactive count within the liver. This is not pathognomonic as hepatoma or metastatic malignancy will present similar patterns.[3]

The case used to demonstrate this discussion shows most of the radiographic findings which can be used as diagnostic aids. Note the cone-shaped cecum, enlarged liver, elevated diaphragm, and the large area of decreased uptake on the radioactive liver scan.

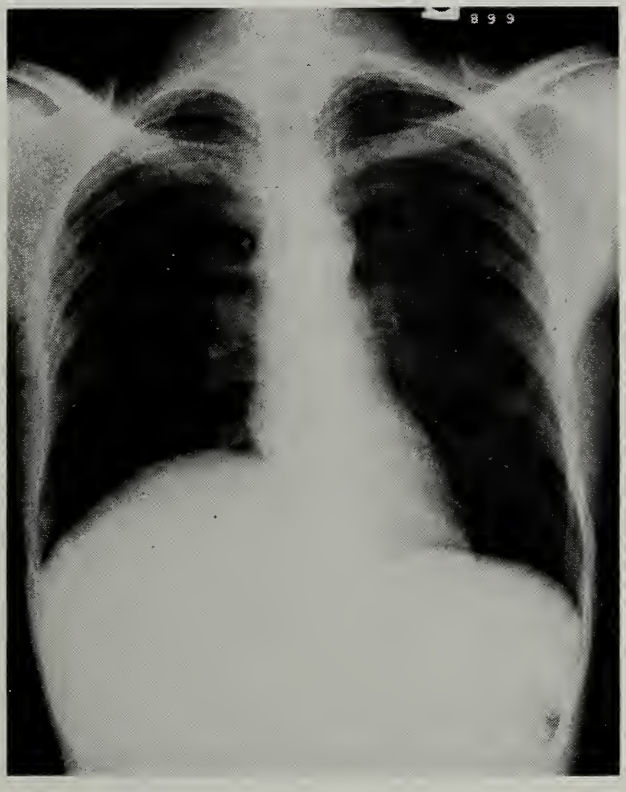


Figure 2. Chest x-ray showing elevation of right hemi-diaphragm. Also, note increased density in upper abdomen due to enlarged liver.



Figure 3. Liver scan superimposed over abdominal radiograph demonstrating enlarged liver with absence of radioactivity in the large abscess cavity within the right lobe of the liver.

This accumulation of findings should lead the radiologist and clinician toward the diagnosis of amebiasis. The final diagnosis, however, is dependent on the demonstration of the organism in the stool. ★★★

Rankin County General Hospital (39042)

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LOW IN THE SADDLE

While examining a Texan who was visiting in my state, I noticed he had a scar on his scalp and questioned him about it. "I got it from being drugged," he told me.

Not seeing the connection, I asked him to elaborate.

"Well," he said, "I was working on a ranch. My horse bolted. My foot got caught in the stirrup. And I was drugged."

—William L. Sands, M.D.

Blood Assurance Plans: An Answer To Blood Shortages

JAMES B. HARTNEY, M.D.
Chicago, Illinois

THE "POSITION STATEMENT on Blood Banks" adopted by the House of Delegates of the American Medical Association, December 1963, points out that the procurement and transfusion of human blood are medical procedures. Since their objective is the welfare of patients, the profession has a paramount interest in procdures for blood procurement, best discharged by medical societies at the local level.

The Committee on Blood of the American Medical Association has pointed out that the primary interest of physicians is to secure an adequate, efficient, and economical supply of safe, usable blood for patients. The profession has a responsibility to exert leadership and to participate actively to advance high standards in blood banking and blood use. The American Medical Association favors the replacement of blood "in kind" and opposes dollar payment for whole blood, while noting that exceptions may need to be made in cases where an unusual number of transfusions are required.[5]

What constitutes an "adequate" blood supply? This can only be determined at the local level by careful review of community experience. Consideration of adequate blood supply demands attention to the total annual requirement, maintenance of daily inventory requirements, and requires attention to certain special inventory problems. The "annual requirement" can be roughly estimated as equivalent to approximately 3 per cent of the population. This must be increased by an attrition factor to allow for inventory losses due to outdated or otherwise unusable blood.

Additional requirements are imposed by such special transfusion needs as those related to programs of chronic dialysis, organ transplantation, or special component needs such as the need for platelet concentrates in thrombocytopenic patients, especially those whose condition is potentially reversible and related to marrow suppression in the course of tumor chemotherapy or immunosuppressive treatment programs.

An adequate blood supply for a given community must be determined on the basis of community experience, but the medical profession has a paramount interest in the procedures for blood procurement. The author notes that safe blood supplies are best obtained by the use of volunteer donors and that blood assurance programs are one highly effective means of accomplishing this.

As a function of the total annual requirement, the daily inventory requirement (representing blood "on the shelf") can be estimated at 5-10 days normal utilization. It should be distributed by normal population incidence of group and type, combining group B with group O to derive the group O requirement, Group AB with group A to obtain the group A requirement.

Certain special problems must be given careful consideration. Increased procurement effort prior to weekends and holidays, especially holiday weekends, is essential if severe inventory depletion is to be avoided. It is necessary to anticipate seasonal slumps in availability of donors during the summer vacation period and from approximately Dec. 15 to Jan. 10. Decreased donor availability can be anticipated in periods of epidemic illness, civil unrest or disturbance with decreased freedom of movement, and in periods of natural disaster such as storm or flood.

Based on the approximately 600,000 population of Jackson and its retail trading area, using

Member, Committee on Blood, American Medical Association.
Read before Central Medical Society, Jackson, March 4, 1969.

a 3 per cent of population basis, one might anticipate an annual requirement of some 18,000 units of whole blood for transfusion, exclusive of attrition and special transfusion requirements. It is of interest to compare this with the figures presented in the AMA's 1965 "Directory of Blood Banking and Transfusion Facilities and Services."[3] During 1964, 17,966 units of blood were collected in Jackson, received by reciprocity or were purchased from outside sources. With an additional arbitrary allowance of 5 per cent for attrition and 10 per cent for special transfusion requirements, approximately 65 blood donors per day will be required during a six-day work week throughout the year to maintain this community in a self-sufficient status for its whole blood requirements.

FACTORS OF SAFETY

Assuming technical competence in the collection, storage, pre-transfusion processing and administration of blood, a "safe" supply can be equated with blood having minimum risk of transmittal of disease, especially infectious hepatitis. It is repeatedly suggested that blood derived from donors compensated in cash for blood donation may be associated with a higher incidence of hepatitis. This has been related to the desire of the donor to receive monetary compensation. It has been suggested that post-transfusion replacement donors may have some of the same motivation, related to the desire to secure refund of "blood responsibility" or "penalty" fees. The belief is currently growing that an individual who desires to assure family protection by donation prior to the time of need may have less incentive to conceal the facts of his medical history, especially if protection can be secured by payment of a refundable benefit fee when the donor is temporarily medically unacceptable.

It would seem that since participation by only 3 per cent of the population is necessary to maintain the community's inventory of blood for transfusion, little difficulty would be experienced in maintaining stocks at an adequate level. Such, indeed, is not the case. Those charged with responsibility for the operation of blood banks and transfusion programs are all too familiar with the recurring problem of "blood shortages" especially over weekends, during the Christmas holiday period, and during the summer vacation months. Relatively little has been done to study the negative motivation of those individuals who do not donate. Fear of the needle certainly plays a part, the feeling of "let George do it" must certainly be involved, deeply seated and indeed unrecognized fear of loss of a portion of the person may well be significant.

The experience of communities where an aggressive program of blood donor recruitment is carried on would seem to indicate that much can be done by an effective public information program. Completely independent of the negative factors already mentioned, many people do not donate blood because they are unaware of the need for blood donors. Public ignorance, indifference, and apathy are perhaps the greatest obstacles to maintaining an adequate inventory of safe blood for transfusion.

A complicating factor is the existence of indemnity programs which will pay in cash for the "responsibility fee" or "penalty charge" usually levied against the recipient of transfusion and designed to provide an incentive for replacement. The American Medical Association opposes such programs and believes they should be eliminated wherever possible. In most cases, Blue Cross programs, while paying the laboratory charges incidental to blood transfusion will not compensate the patient for the "cost of blood itself." Similarly, beneficiaries of the "Program of Health Insurance Benefits for the Aged" under Social Security are required to replace the first three units before the program will provide for payment of responsibility fees.

In some areas, population characteristics related to age distribution, prevalence of disease, inadequate nutritional status or other factors may reduce the available donor pool. Peak periods of respiratory infection can be an especially serious threat to blood inventory maintenance. This was the experience in many cities during the past winter.

MECHANISMS FOR ASSURING SAFE BLOOD SUPPLY

1. Reduce reliance on paid blood donors except for carefully screened individuals who may be called upon regularly (every eight weeks, not over five times per year) for special situations, such as plasmapheresis in programs for preparation of platelet concentrates.

2. Evaluate and consider the possible use of autotransfusion where appropriate. This has been recommended for elective surgery in otherwise healthy individuals who meet the requirements for blood donation with respect to hemoglobin levels, cardiac and blood pressure status.[2]

3. Encourage or require pre-admission blood deposit. This has been advocated in some communities for those patients in whom transfusion may reasonably be anticipated during the course of hospitalization.[1]

4. Mobilize voluntary blood donors by establishing and conducting aggressive programs of public information and by the establishment of blood assurance programs.

A program of blood assurance is one in which individuals, in return for blood donation, are relieved of the necessity of providing replacement blood donors for whatever numbers of transfusions they or specified members of their family may receive during the assurance period. An "assurance" program differs from an "insurance" program in that the latter, in return for a cash premium, undertakes to indemnify the recipient of transfusion for the cost of blood replacement. Blood assurance programs include:

Community coverage, such as the "total supply program" of the American National Red Cross. In return for filling an assigned quota of blood donors, the program undertakes to supply the blood needs of individuals and hospitals in the community for a specified period, usually one year.

GROUP PROGRAMS

Group programs, which include those conducted by fraternal, business and industrial organizations. In the past, such programs have often established credit reserves for their members by blood donations, replacement for members of the organization being limited to a number of units equal to the units donated. The current pattern is to assure all members of the group and their families when a stipulated percentage (such as 20 per cent) of the membership has donated.

Family programs which provide that independent of community or group membership, the family may assure its needs for a specified period by blood donation. In one program, donation of a unit of blood will assure an individual for four years, husband and wife for two years, husband, wife and dependent children for one year.

The blood assurance program of the Northern Illinois Blood Bank, Rockford, Ill., was established in 1952 with the founding of the blood bank. This organization is supported by the medical societies of Winnebago, Boone, and Ogle counties and collects essentially all of the blood used in the hospitals of these three counties. The territory served by the bank includes Rockford, the second largest city in Illinois, small cities and rural areas.

The assurance program provides family coverage for a $2 annual record-keeping fee and the promise to provide an acceptable blood donor when called upon. Currently, a family head is called upon to donate (or provide a substitute donor) approximately every two years. Since this is a family program with community features, the family is covered under the community plan when medical reasons prevent blood donation. When an individual is called upon to donate, an alternate date is provided if the first date suggested is inconvenient. A family will be dropped from membership for failure to provide a donor in response to three requests.

CENTRAL FACILITY

The Northern Illinois Blood Bank operates a centralized blood donor and processing facility and blood is provided from this point to maintain the in-hospital stocks of the community. The assurance program covers blood replacement requirements but does not provide dollar coverage for laboratory or blood administration charges. This program has the advantage of permitting a phased input of donors and permits some degree of inventory control. It works well in the relatively closely knit area which it serves, where people are known to their neighbors and a highly developed sense of community responsibility has grown up over the years.

The Cooperative Blood Replacement Plan which operates in metropolitan Chicago provides for family coverage subsequent to blood donation. This practice of donation before coverage rather than on call seems to work better in an area of metropolitan anonymity. The program is sponsored by approximately 150 community, industrial, fraternal and union organizations; blood donation may be made at any of 53 participating hospital blood banks. The plan operates on a basis of "paper flow" rather than physical transfer of blood.

ACCOUNTING PROCEDURE

When an individual donates, the hospital in which the donation is made adds the blood to its own inventory and sends a notice to the plan office. Blood provided to plan participants is replaced by credit-transfer through the North Central District Clearinghouse of the American Association of Blood Banks, by shipment of processed blood from one of the NIH licensed supplemental blood banks in the community or (in exceptional cases) by cash settlement with the institution. Individuals temporarily or permanently

unable to donate are encouraged to provide an alternate donor but may enroll in the plan by payment of a benefit fee (currently, $10) which is refundable if blood donation is subsequently made.

The public educational requirements of the Cooperative Blood Replacement Plan are perhaps somewhat more complex than those found in a smaller community. Techniques employed include the provision of posters for hospitals, displays and display stands for membership informational brochures and application forms in doctors' offices, use of news media to publicize an annual Blood Donor Week, awards to participating organizations in the form of certificates, the maintenance of a grant-in-aid program for medical technologists and the provision of monthly rosters to hospitals of those individuals, previously donating at that institution, whose membership is to expire during the following month.

The Cooperative Blood Replacement Plan was established in 1957. Originally sponsored by the Chicago Blood Donor Service, a not-for-profit supplemental blood bank licensed by the National Institutes of Health and directed since its inception by Coye C. Mason, M.D., the plan recruited 119 members in its first full year of operation. By 1961 the plan had matured sufficiently to justify its establishment as a separate Illinois not-for-profit corporation with its own Board of Directors, its own offices, and it is now completely autonomous.

PARTICIPATION IMPACT

During 1968, 20,071 new and renewal members were enrolled; projection from past growth experience indicates that as of the close of the current calendar year, the blood needs of approximately 127,000 Chicagoans will be assured through participation in the plan. Over the years of its existence, the plan has consistently liberalized its protection by eliminating exclusions from coverage.

At the present time, the blood needs of mother and infant can be covered by a donation made at any time prior to delivery, erythroblastosis and known Rh sensitization are not excluded; full protection is provided for blood dyscrasias developing after enrollment. An experimental program of assurance protection for hemophiliacs is now being developed and will be initiated on a limited basis to obtain necessary experience factors for expansion of this program.

The responsibility of the medical profession to exert leadership in blood programs has repeatedly been met by physician or medical society initiative in the formation of blood assurance programs. Once established, the members of the profession assume their responsibility to participate actively by informing their patients of the existence of the program, urging their participation, making literature available for patients in their office. It is impossible to lay too much stress on the importance of the primary physician, whether he be in solo family practice, a member of a medical group, a staff member of an institutional out patient department or admitting service, in enlisting patient cooperation in contributing to the blood needs of the community.

M.D.'S IMPORTANCE

The physician on whom the patient places most reliance is the one who can do most to stimulate blood donation and membership in the community's assurance program. He can advise the patient in advance of hospitalization of the possible need for replacement blood donors and consider the advisability of auto-transfusion in appropriate circumstances. He can also reduce blood requirements of the community by judicious selection of candidates for transfusion, choosing other methods of treatment where appropriate, always weighing the hazards of transfusion against the benefits to be achieved.[6]

The AMA has a deep interest in promoting the concept of voluntary blood donation and informing physicians and the public on matters concerned with blood procurement as well as blood utilization. To advance these ends, two publications are prepared under the auspices of the Committee on Blood, AMA. The "Directory of Blood Banking and Transfusion Facilities and Services" and the monograph "General Principles of Blood Transfusions,"[4] originally prepared by the Subcommittee on Transfusion Problems, National Academy of Sciences—National Research Council, are widely used and have been helpful to many physicians. Both are now under revision and new additions should appear in 1969. In addition, the Committee on Blood has prepared one of the "Timely Tips" series, dealing with the subject of blood donation and designed for wide distribution to patients. This publication will be available from the AMA Circulation and Records Department.

SUMMARY

Members of the medical profession are concerned with the maintenance of adequate supplies of safe blood for their patients. What constitutes

"adequate supply" for a given community must be determined on the basis of community experience. It is currently believed that "safe" blood supplies are best obtained by the use of volunteer donors and that blood assurance programs are one highly effective means of accomplishing this.

A community blood assurance program may emphasize donation on call, donation prior to assumption of the assurance obligation by the plan, should provide a mechanism for membership open to individuals medically unable to donate. The practicing physician can advance this assurance program by encouraging his patients' participation and is undoubtedly the key to any successful blood program emphasizing voluntary donors. ★★★

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UNDERCOVER MAN

Arriving home, the absent-minded professor told his wife he'd forgotten to take his umbrella that morning. She asked, "When did you miss it, dear?"

"When I reached up to close it after the rain had stopped."

Clinicopathological Conference XCIV

Conducted by the Department of Pathology
Mississippi Baptist Hospital
Jackson, Mississippi

THIS 83-YEAR-OLD, retired farmer entered the hospital because of abdominal pain and backache for "several weeks," and vomiting for two to three days.

Two years previously he had been admitted for a perforated gastric ulcer. The perforation had been preceded by intermittent abdominal pain for two weeks, followed by progressively more severe pain, vomiting, and hypotension. At surgery a chronic ulcer of the lesser curvature of the stomach was found, which was perforated and eroding just superficial to the common duct. There was marked peritoneal contamination of the right subdiaphragmatic and subhepatic areas. The perforation was closed, and the patient made a rapid recovery.

Apparently, the patient remained fairly well until the present admission, although specific details are lacking. However, for at least two weeks prior to this admission, he had had upper abdominal pain and back pain. This had been in the right upper quadrant and mid-epigastrium, radiating to the right side of the back, and somewhat to the interscapular region and right shoulder. The pain had been quite severe, and the patient had begun to vomit. The vomiting was said to have begun soon after the onset of the pain. However, the history was difficult to obtain because of the patient's senility and grave illness, and it was not clear as to whether the pain had been sudden in onset, or whether it was constant or intermittent, or whether the pain or vomiting came first.

On examination, bloody vomitus was noted on the patient's clothes. The blood pressure was 100 systolic, and the patient was said to be hyperventilating, with periods of apnea. The heart and lungs were unremarkable. The abdomen showed slight, diffuse tenderness and muscle guarding, which was not considered to be impressive. The pain was much worse on movement of the torso.

The hematocrit was 52 percent, white count 13,700, and urinalysis normal. BUN, electrolytes, and amylase were normal. Chest film showed some haziness of the left lower lung field at the periphery, with blunting of the left costophrenic sinus, thought possibly to represent a small amount of fluid in the left pleural cavity. Abdominal films showed good visualization of the psoas shadows, no urinary or biliary calculi, no significant gas in the small intestine, and no free air in the peritoneal cavity. An EKG was normal.

The patient's temperature remained around 100 degrees orally, with a pulse about 80, and blood pressure around 110/80. The initial diagnosis was bleeding duodenal ulcer, and he was given one unit of blood. However, the hematocrit the next day was 50 per cent, and since no bloody material was vomited, or aspirated via Levin tube, the bleeding was thought to have stopped. The feces remained brown. On the second day, the patient continued to complain of severe right upper quadrant and right infrascapular pain, and bowel sounds were absent. He was noted to be oliguric. The BUN was 61 mg. per cent, and a mannitol infusion failed to produce a diuresis. The serum osmolality was normal. The patient became cyanotic, with shallow breathing, the pulse rose, and blood pressure dropped, and the patient expired.

The patient in this month's CPC was admitted to the hospital with symptoms of abdominal pain and backache for several weeks and vomiting for two to three days. Two years previously he had been admitted for a perforated gastric ulcer. Discussers are Drs. Henry B. Tyler, Ottis Ball, and William B. Wilson.

Dr. Henry B. Tyler: "This 83-year-old, retired farmer entered the hospital because of abdominal pain and backache for several weeks, and vomit-

ing for two to three days. Two years previously he had been admitted for a perforated gastric ulcer. The perforation had been preceded by intermittent abdominal pain for two weeks, followed by progressively more severe vomiting and hypotension. At surgery, a chronic ulcer of the lesser curvature of the stomach was found, which was perforated and eroding just superficial to the common duct. There was marked peritoneal contamination of the right subdiaphragmatic and subhepatic areas. The perforation was closed, and the patient made a rapid recovery.

"So, this is an 83-year-old gentleman, whom we know already had had peptic ulceration, with a two-year symptom-free interval in between. Apparently, the patient remained fairly well until the present admission, although specific details are lacking. (That's an understatement.) However, for at least two weeks prior to this admission, he had had upper abdominal pain and back pain. This sounds like the first admission. This had been in the right upper quadrant and mid-epigastrium, radiating to the right side of the back and somewhat to the interscapular region and right shoulder areas.

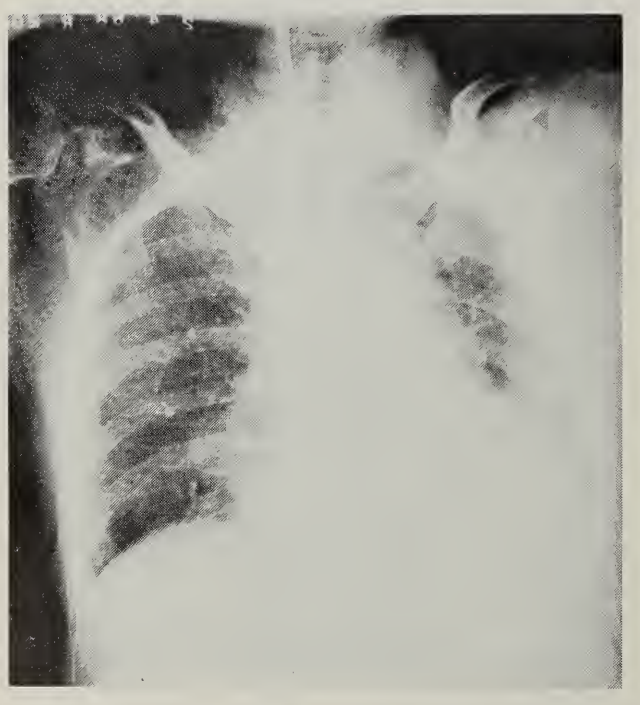
DIAGNOSTIC IMPRESSIONS

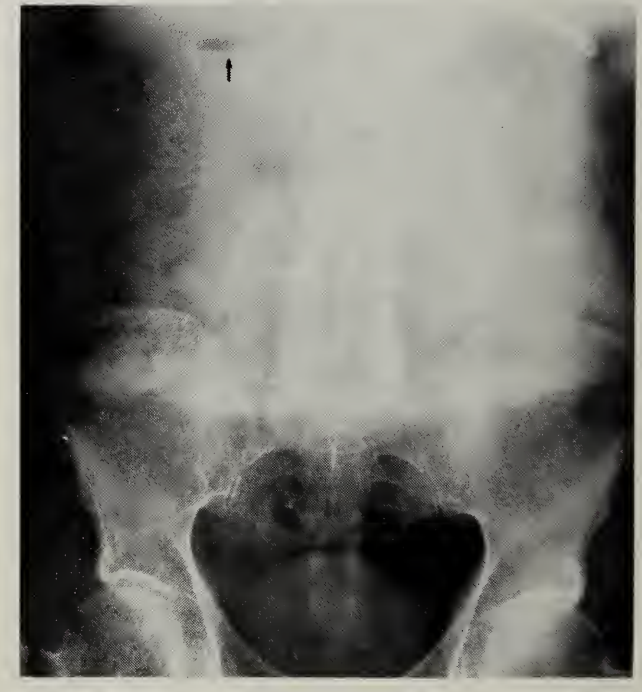
"From this point we begin to think that there is some irritation in the dome of the diaphragm, or, at least, some irritation of the phrenic nerve. The pain had been quite severe, and also, had been persistent. However, the history was difficult to obtain because of the patient's senility and grave illness, and it was not clear as to whether the pain had been sudden in onset, or whether it was constant or intermittent, or whether the pain or vomiting came first. In other words, we don't have much of a history.

PHYSICAL EXAMINATION

"On examination, bloody vomitus was noted on the patient's clothes. So, we have a new item here, an elderly man, severe back pain, epigastric pain and now some bloody vomitus on his clothing; where the blood came from I don't suppose anyone knows. The blood pressure was 100 systolic. I think this is an important thing to remember. The patient was either hypotensive or normotensive, but at least not hypertensive. We don't know what the blood pressure was on the previous admission. The patient was also noted to be hyperventilating. So, again we have a suggestion of some irritation of the diaphragm.

"The heart and lungs were unremarkable. This is pertinent in that we have a man with severe back pain radiating around to his mid-scapular area, but who has a normal-sounding chest, tending to rule out some pneumonic process. The abdomen showed slight diffuse tenderness and mus-





Figures 1 and 2. Chest and semi-erect abdominal x-rays on admission. Arrow indicates air fluid level in the right upper quadrant. See text.

cle guarding, which was not considered to be very impressive. So the abdominal findings are not very impressive in this man, though his pain is severe. The pain was much worse on movement of the torso. I think that will be a significant point.



Figure 3. Stomach and esophagus removed en bloc at autopsy. The probes lie crossed in the stomach, pass through two rents side by side at the squamo-columnar junction of the esophagus, and into the posterior mediastinum.

"The hematocrit was 52 per cent. The WBC was 13,700, and the urinalysis was normal. A hematocrit of 52 per cent in a sick elderly gentleman suggests to me hemoconcentration, probably again secondary to dehydration. We do not know what his hematocrit was on that previous admission, so as to know what the normal for him is. The BUN, electrolytes and amylase were normal on admission.

LUNG FIELD

"The EKG was normal. Chest film showed some haziness of the left lower lung field at the periphery, with blunting of the left costophrenic sinus, thought possibly to represent a small amount of fluid in the left pleural cavity. So whatever this gentleman's problem is, it not only causes him severe pain in his back, not only is causing him to hyperventilate with periods of apnea, but also has caused a minimal amount of pleural effusion and some pneumonic streaking. The abdominal films showed good visualization of the psoas shadows. There were no urinary or biliary calculi found. There was no significant gas in the small intestine and, of greater interest, no free air was noted in the peritoneal cavity. This is an item that I think we ought to take another look at, and I would like to look at the films now along with the radiologist."

RADIOLOGIC FINDINGS

Dr. Ottis Ball: "The admission chest film of February 4, 1968 was portable in technique and recumbent in position. The upper lung fields are clear. There is haziness in both lower lung fields, somewhat more so on the left, with an associated pleural reaction obscuring the left hemidiaphragm. There are also a few, linear, band-like densities in the right lung base. The heart and mediastinum are somewhat difficult to evaluate on a study of this type. However, the heart appears to be at least at the upper limits of normal, and there is suggested slight widening of the mediastinum. A Levin tube is seen to be in place in the stomach.

"Recumbent and semi-erect films of the abdomen reveal a small air-fluid level in the right upper quadrant of the abdomen, which could be outside of the bowel, but could possibly be within the duodenum. The intestinal gas pattern is otherwise unremarkable in appearance, and the visualized soft tissue and bony structures otherwise appear essentially normal.

"My impressions are bilateral lower lobe pneumonia with an associated pleural reaction left lower chest; suggested minimal cardiomegaly; equivocal widening of the mediastinum; suggested small air-fluid level in the right upper quadrant of the abdomen, which could be in a subphrenic abscess, or represent a small hemoperitoneum. However, this, too, is somewhat equivocal and could simply represent gas and fluid within the duodenum. The abdomen is otherwise normal. (See Figures 2 and 3.)"

Dr. Tyler: "The patient's temperature remained around 100 degrees while in the hospital, with a pulse of around 80, and the blood pressure around 110/80. Thus we have some confirmation that he was not hypertensive. The initial diagnosis was a bleeding duodenal ulcer, and he was given one unit of blood. However, the hematocrit was 52 (probably reported after the blood was started), he never had tachycardia, and no bloody material was vomited after admission, nor was it aspirated via Levin tube. The bleeding, therefore, was thought to have stopped. The feces remained brown. It takes probably about 40 to

50 cc. of blood to cause a tarry stool, so I doubt that the bleeding is going to be of any significance to us here, though it is something we will have to keep in mind.

"On the second day the patient continued to complain of severe right upper quadrant and right infrascapular pain. This seems to be very significant. The bowel sounds were now absent. He was noted to be oliguric. The BUN was 61 mg. per cent. Of course, this again could be a rapid progression of what might have been present initially with a moderate amount of dehydration in this elderly gentleman. A mannitol infusion failed to produce a diuresis, but I don't necessarily think that this rules out oliguria secondary to dehydration particularly if he did not have a priming infusion of some volume of fluid before the mannitol was given. Serum osmolality was normal.

"The patient became cyanotic with shallow breathing. The pulse rose and the blood pressure dropped, and the patient expired. So, whatever subacute or chronic course this man had at home for two weeks, it was apparently followed by a crisis just before hospitalization, it seems. Something turned catastrophic and caused him to expire rather rapidly, in contrast to a course of steady deterioration. Coincident with the catastrophe, he developed oliguria and a rapidly rising BUN.

HISTORY OF ULCER

"Now, the thing first of all to come to mind—I'll just run over these briefly—is peptic ulceration. We know he had a perforated gastric ulcer two years ago, and we know that 70 per cent of the people who perforate once will do it again. A likely possibility is that this gentleman perforated an ulcer. He did not have the board-like abdomen that you would expect from a perforation of aviscus, particularly one that had gastric contents in it. However, he did have severe pain on movement of his torso, which is pretty typical of a perforation of a duodenal or gastric ulcer.

"Why didn't he have the board-like abdomen? Of course, he has had an operation and he has had a perforated ulcer previously. He would certainly have adhesions which might have localized the peritonitis. Or, there might have been a posterior perforation into the lesser sac, again with localization. The perforation could have been high up near the fundus of the stomach, and his whole problem could have been a perforation of the stomach under dome of the diaphragm area, which could have caused pleural effusion or pleuropneumonic process, and also some widening of the mediastinum with inflammation, either chemical or bacterial.

DIFFERENTIAL DIAGNOSES

"Could this initially have been a carcinoma of the stomach that was sutured over the first time? I doubt it. He had had a two-year symptom-free interval. I think we can pretty well forget about that.

"How about gallbladder disease? He had right upper quadrant pain but he was never tender there. A mass was never noted, he never had any real biliary symptoms in the past, and he was not jaundiced on this admission. Of course, it could have been biliary colic or inflammation, followed by perforation of the gallbladder; this could certainly cause his demise. But without any physical signs pointing to disease in the right upper quadrant, I think acute cholecystitis is unlikely as a cause of infrascapular pain.

"Pancreatitis certainly could be creating this same type of pain. However, typically, the pain with pancreatitis is not increased on movement of the torso. We also know that he had a normal amylase. He also had no history of alcoholism and no history of gallstones in the past. So in my mind I have pretty well eliminated pancreatitis, and unless it was of a severe nature it also would not have caused that sudden a demise.

"I think our films rule out intestinal obstruction as does the lack of distention on physical examination. There are rare diagnoses to be considered, such as rupture of the splenic artery aneurysm, of an hepatic artery aneurysm, of aneurysms of any arteries in the abdomen. I don't feel that a normal hematocrit over a two-day period of time would be compatible with this. Also, it wouldn't cause some of the other manifestations that this man had. These are most of the things which could occur in the abdomen that would create a problem like this.

CHEST PAIN

"What are things in the chest that create severe pain of this nature? Of course, a myocardial infarction could mimic all of these; it could give you acute chest pain, back pain, and certainly could lead to a rapid demise. However, this man had a normal EKG, and he had had no history of angina in the past, and none of the other cardiac findings that would be compatible with

myocardial infarction. He could have had pneumonia, but again he had had no rales or rhonchi, at the time the lungs were examined, anyway. Pericarditis, I think, would be unlikely.

"Dissection of the thoracic aorta is a real possibility in this man. He could have had widening of the mediastinum as you see here. He had the excruciating pain that you most often get. Dissection could explain the rapid rise in BUN if it went down to the renal area, and also many other findings in this case, so it is a real consideration. However, what differed in this man is that his pain was constant and was extremely severe, and, most of the time thoracic aortic dissection causes an extreme amount of pain initially and then tapers off.

"There is no statement in the protocol about whether the peripheral pulses were all full and equal. In a thoracic aortic dissection of this magnitude, one would expect to find at least one of the major pulses diminished or absent. Apparently this was not noted, so we will have to consider this an important negative finding against aortic dissection. Also, typically, pain from dissecting aortic aneurysms usually is not increased on movement, or on taking deep breaths, as this man's pain seemed to be. He could have had a retroperitoneal perforation or rupture of an aortic aneurysm, but I think this is unlikely in view of the normal hematocrit and normal pulse preterminally.

"A diagnosis which might tie everything in, though it's a rare phenomenon, is perforation of the esophagus; and a most common location, at least spontaneous perforation of the esophagus, is in the lower third. This usually causes excruciating pain. If the rent is large, it could cause death in 48 hours. The thing that bothers me about this diagnosis is that it is very rare. However, in this man maybe it wasn't the typical perforation of the lower esophagus secondary to vomiting. Perhaps he had esophagitis. We know he had peptic ulcer disease. Perhaps he had a lower esophageal ulcer which perforated. Again, this is rare, but it does occur.

MEDIASTINAL INVOLVEMENT

"In either case the perforation can cause widening of the mediastinum, which I think is present on the chest x-ray, which would probably mean inflammation within the mediastinum. I feel that it is difficult for me to decide whether to label this 'perforation from the high stomach' or 'from the lower esophagus.' I feel fairly certain that the pathology originated in that area, however, since we have the irritation of the dome of the diaphragm, we have x-ray evidence of mediastinal involvement, and we have definite pleural effusion. I think it is too long a period of time to have a sterile subhepatic or subdiaphragmatic abscess from the previous operation which would suddenly create this sort of problem.

PROVISIONAL FINDING

"The only thing against perforation of the stomach in this area is that it usually does not cause such sudden and severe pain; and yet, perforation of the esophagus, if this had occurred when he first started vomiting two weeks before hospitalization, would have been fatal long before he even got to the hospital here. So, I'm going to stick my neck out and say that I think this man probably was vomiting secondary to his ulcer diathesis, and that shortly before or after coming into the hospital perforated his lower esophagus."

Dr. William B. Wilson: "Thank you, Dr. Tyler. When I asked Dr. Tyler to present this case, I told him I didn't think it could be diagnosed on the basis of the clinical information that we have, but he was a good sport and agreed to take it, anyhow. Now I see I didn't give him enough credit, and I congratulate him on his excellent analysis of this case and correct diagnosis of perforated lower esophagus.

"When the abdomen was opened, the peritoneal cavity was found to be almost completely normal, except for some old fibrous adhesions in the right upper quadrant, related to the previous surgery, and a few fibrinous, recent adhesions between the left lobe of the liver and the overlying diaphragm. On opening the chest, about 2 to 3 liters of gray, cloudy, odorless fluid was found in each pleural cavity, and there was a thick, tenacious, yellow exudate over both pleural surfaces. The lungs showed extensive atelectasis.

"The mediastinal tissues were gray, friable, and wet. The stomach mucosa was edematous, and bright red, with some thin, white exudate on it. Microscopically, some plasma cell infiltrate and mucosal congestion were seen in the stomach. This mucosal congestion of the stomach probably was related to venous obstruction by the mediastinitis after esophageal perforation, and I do not think it played a role in the genesis of his vomiting or perforation.

"The duodenum showed some old thickening of the posterior wall, and microscopically showed acute, superficial ulceration of the mucosa, extending down to, but not into the muscularis, with fibrin and old scarring at the base. This duodenal

ulcer disease probably caused vomiting (not obtainable by history) and resulted indirectly in the esophageal perforation, as Dr. Tyler surmised.

"This photograph (Figure 3) demonstrates the perforation in the esophagus. As you can see, probes are inserted into two separate perforations on the posterior wall of the esophagus, which lead upward, posteriorly, and laterally. These communicated through the mediastinum into the pleural cavities, bilaterally. Each perforation is a 1 cm. long rent, occurring exactly at the squamocolumnar juncture of the esophagus. This actually is in the lower esophagus. The kidney showed tubular necrosis, apparently on the basis of hypovolemia with loss of renal perfusion. There was cloudy swelling of the liver, and lipid depletion and tubular degeneration of the adrenal cortices, all considered to be non-specific manifestations of 'toxicity.'

"The history of severe vomiting, followed by acute chest pain, is so typical of esophageal perforation, that the diagnosis supposedly can be made over the telephone. Diagnosis can best be confirmed or excluded by emergency x-ray of the esophagus, using absorbable contrast media, which should show leakage of material into the mediastinum. Early diagnosis is essential, because surgical closure of the esophagus rarely saves the patient after mediastinitis has developed, which occurs in a matter of hours. With early surgical closure, the prognosis is good. There is no place for conservative treatment of this disease, unless the patient is seen late, after mediastinitis has developed, and then the prognosis is very poor.

"Perforation of the esophagus may be spontaneous, or due to instrumentation. The symptoms of esophageal rupture depend on the level of rupture. Subphrenic rupture resembles perforated stomach. Intrathoracic rupture causes substernal or epigastric pain or both, accompanied by pleurisy later, if the pleural cavity is entered. With rupture in the lower esophagus, which is by far the commonest site, the clinical picture may suggest perforated peptic ulcer, with epigastric pain, but there usually is substernal, or interscapular pain, and often shoulder pain.

"The differentiation of perforated lower esophagus from perforated stomach is suggested by the absence of a board-like abdomen in the former, which was an important sign in this case, as Dr. Tyler pointed out. Characteristically, the patient will be found motionless and in a sitting position. Spontaneous rupture of the lower esophagus usually occurs in patients with a history of upper gastrointestinal complaints, and often follows a heavy meal, or more likely an alcoholic bout, which results in strenuous vomiting. Spontaneous rupture of the esophagus, which has been termed the Boerhaave syndrome, probably is fundamentally similar in pathogenesis to the Mallory-Weiss syndrome." ★★★

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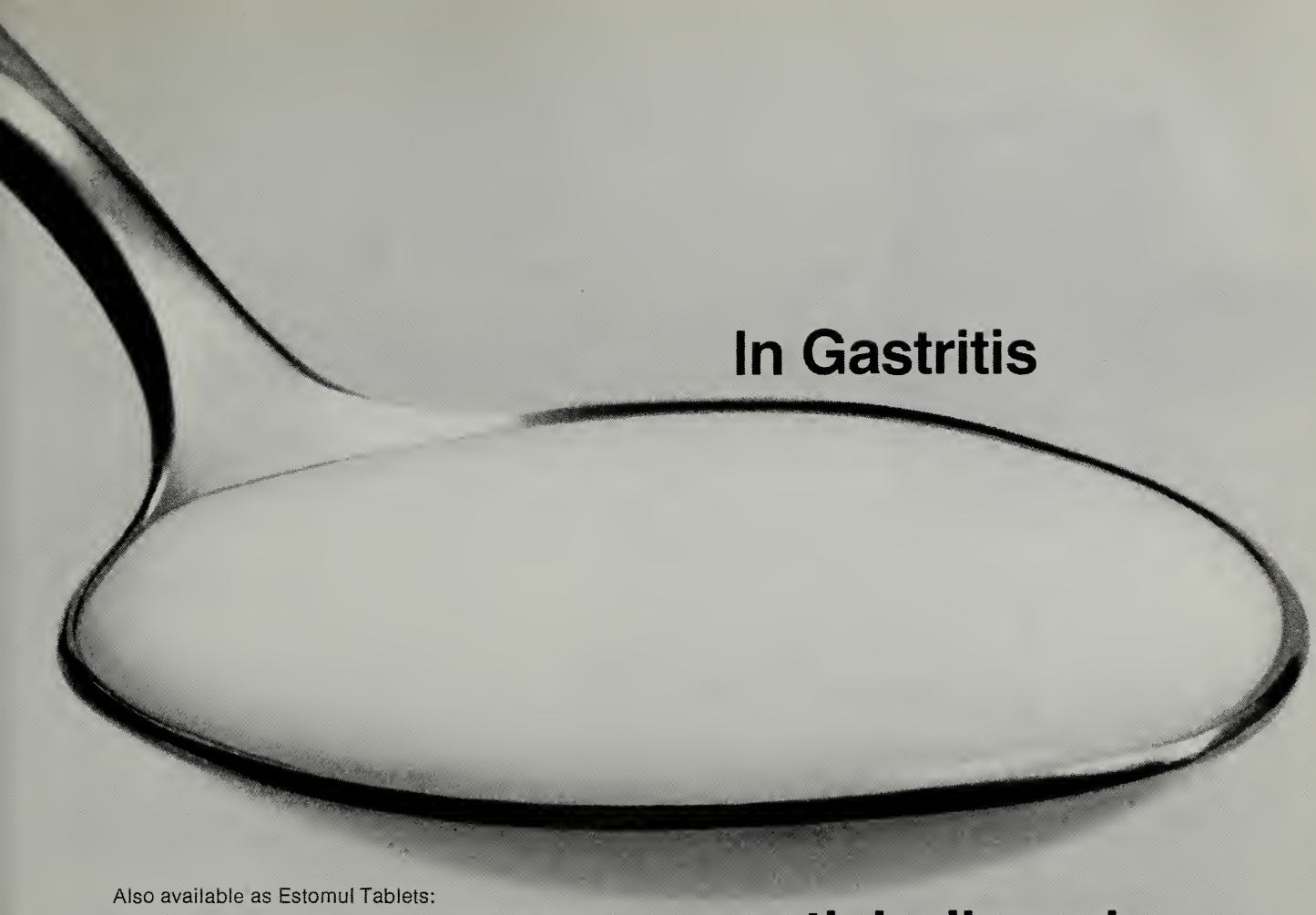
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NOT A DROP

Bet you didn't know there's an organization called, "Hippies Anonymous." It works like this: If a member feels like taking a bath, he phones another member who rushes over and sits with him until the feeling passes.

—*Mississippi Educational Advance*



In Gastritis

Also available as Estomul Tablets:

Each swallow tablet contains: orphenadrine hydrochloride, 25 mg.; bismuth aluminate, 25 mg.; magnesium oxide, 45 mg.; aluminum hydroxide-magnesium carbonate (as co-precipitate), 500 mg.

Indications: Peptic ulcer: duodenal, marginal, gastric, esophageal; gastroesophageal reflux; esophagitis (without stricture); irritable bowel syndrome; hyperacidity and dyspepsia; congenital shortening of esophagus with esophagitis; heartburn; spasm of the cardiac end of esophagus; gastritis; symptomatic hiatus hernia; alcoholic gastritis; functional pylorospasm.

Contraindications: Because of the anticholinergic action of orphenadrine, Estomul should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction at the bladder neck, achalasia (megaesophagus), and myasthenia gravis.

Precautions: Doses in excess of six tablets or six tablespoons of liquid daily may produce minor side actions such as dryness of the mouth or blurred vision.

Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

Availability: On Rx only. 12 oz. bottles of liquid and bottles of 100 swallow tablets.

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The President Speaking

'Wanted'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

WANTED: Physicians who offer suggestions, who raise questions, debate issues, and make good decisions. Minimum requirements for job are membership in medical association and concern over the future of American medicine. All qualified applicants assured of work.

This "classified" ad is my first appeal to my colleagues in our state medical association, and it's a serious invitation to join me in a year of work where every able hand and heart are needed. It has been aptly said that we have a state medical association only for the purpose of doing together what we cannot possibly do alone. This being true, we each have a contribution to make.

Great changes are occurring in the delivery of medical care. Many of these changes are being brought by sources outside the medical community. Government and tax-based sources dedicate progressively larger amounts of money for the purchase of medical care. This alone is a challenge to the private care delivery system. Shortages of professional manpower are aggravated by the broadened purchasing power base, just as they are by the geometric growth of care consumers.

Since our judgments will never be better than our information, we will be challenged to know the score on socioeconomic issues. In a nutshell, we must be active participants in our association, deeply involved in the team effort. The day has passed when any among us can successfully go it alone. Indeed, the association can't make the grade with a few taking on the tasks of many. The classified ad is serious: There are lots of jobs. ★★★

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EDITORIALS

From Flexner to Millis: Six Decades of Miracles

I

MEDICAL EDUCATION in the United States has never been better than it is today. The young medical graduate of 1969 possesses scientific knowledge unknown to the giants of medicine a generation ago. He is armed with chemotherapeutic agents which would have sounded like science fiction to his physician-father. And he has an unparallelled opportunity to enrich and expand his knowledge into tomorrow's forward thrust of science through continuing medical education.

But there is a paradox of progress in this otherwise happy circumstance, because there is too much to know, too little time in which to learn it, and too much limitation upon human capacities to use it. Just as Abraham Flexner sired a revolution in medical education because of deficits 60 years ago, we are challenged to fire the first shot in a second because we have been too successful.

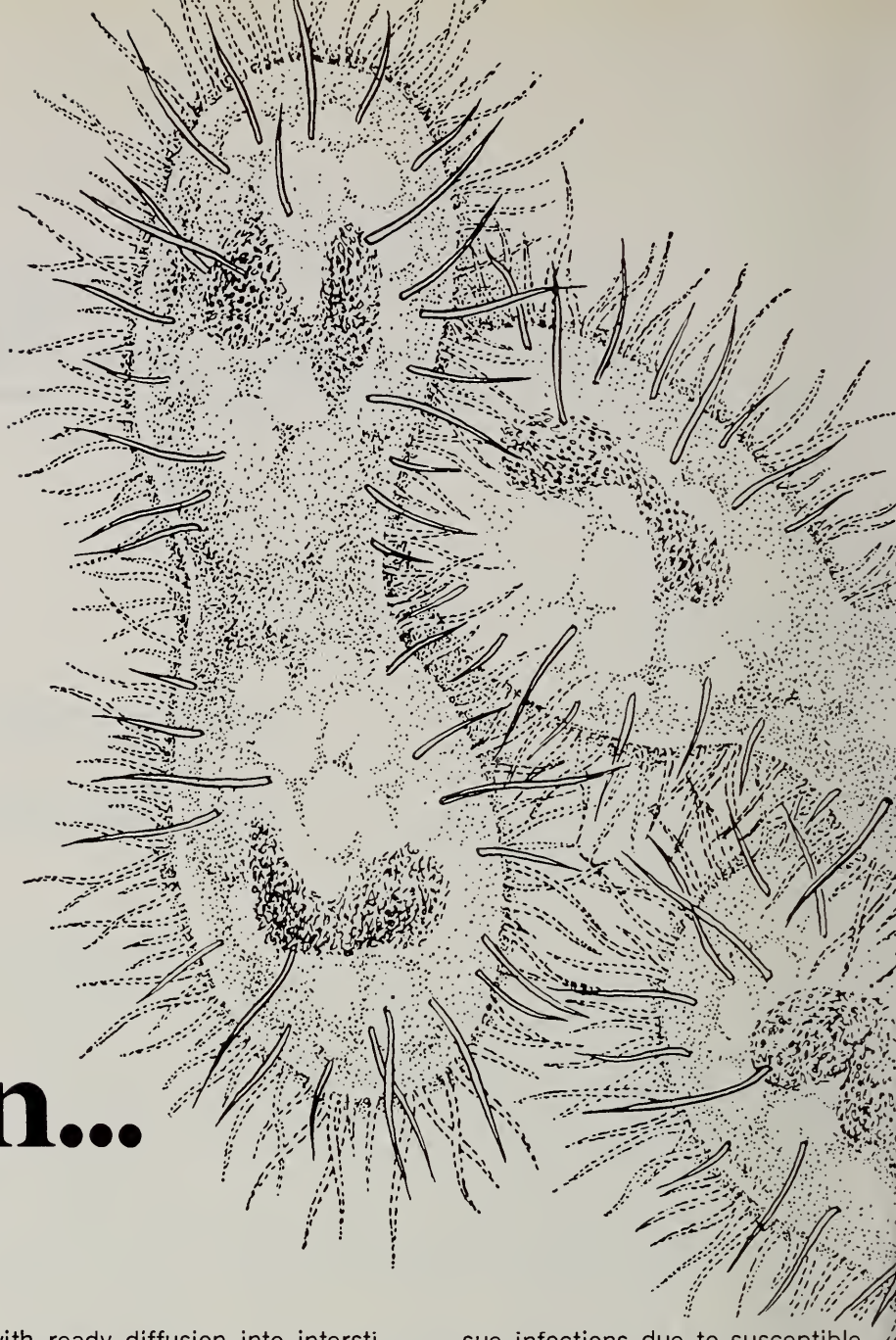
So dramatic have been the strides of the biomedical sciences in the 20th century that we have only to look around us for stunning proof: There are members of the association's Fifty Year Club who received their licenses to practice at the end of their second year in medical school. They had, at that point, learned about all the basic knowledge then available and were challenged to refine the art of medicine in the clinical years. Now we consider the awarding of the undifferentiated M.D. degree as the *midpoint* in the medical education process. If Flexner were around today, he would gasp in disbelief at the deficits of plenty.

II

To a point of unexamined ritual, we like to view medical history in the heroic molds of great individuals. Even now in the day of the team and the system, we still rush to the literature to see who is reporting what first. But with so much to know, the investigator who breaks the barriers today is far more dependent upon the thousands who preceded him in the basic steps than he is upon the spores floating on the wind into the culture by happy chance.

The team concept makes modern medical education possible within the university community. And all of this got started before Dr. Flexner dipped his pen to write the celebrated *Bulletin Number Four* of the Carnegie Foundation for the Advancement of Teaching. William Henry Welch, the real father of modern medical education, was well along his way as dean of Johns Hopkins when Flexner paid the school his first visit.

Of his inspection of Hopkins, Flexner wrote: "This was the first medical school in America of the genuine university type, with something approaching adequate endowment, well-equipped laboratories conducted by modern teachers devot-



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine,* ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

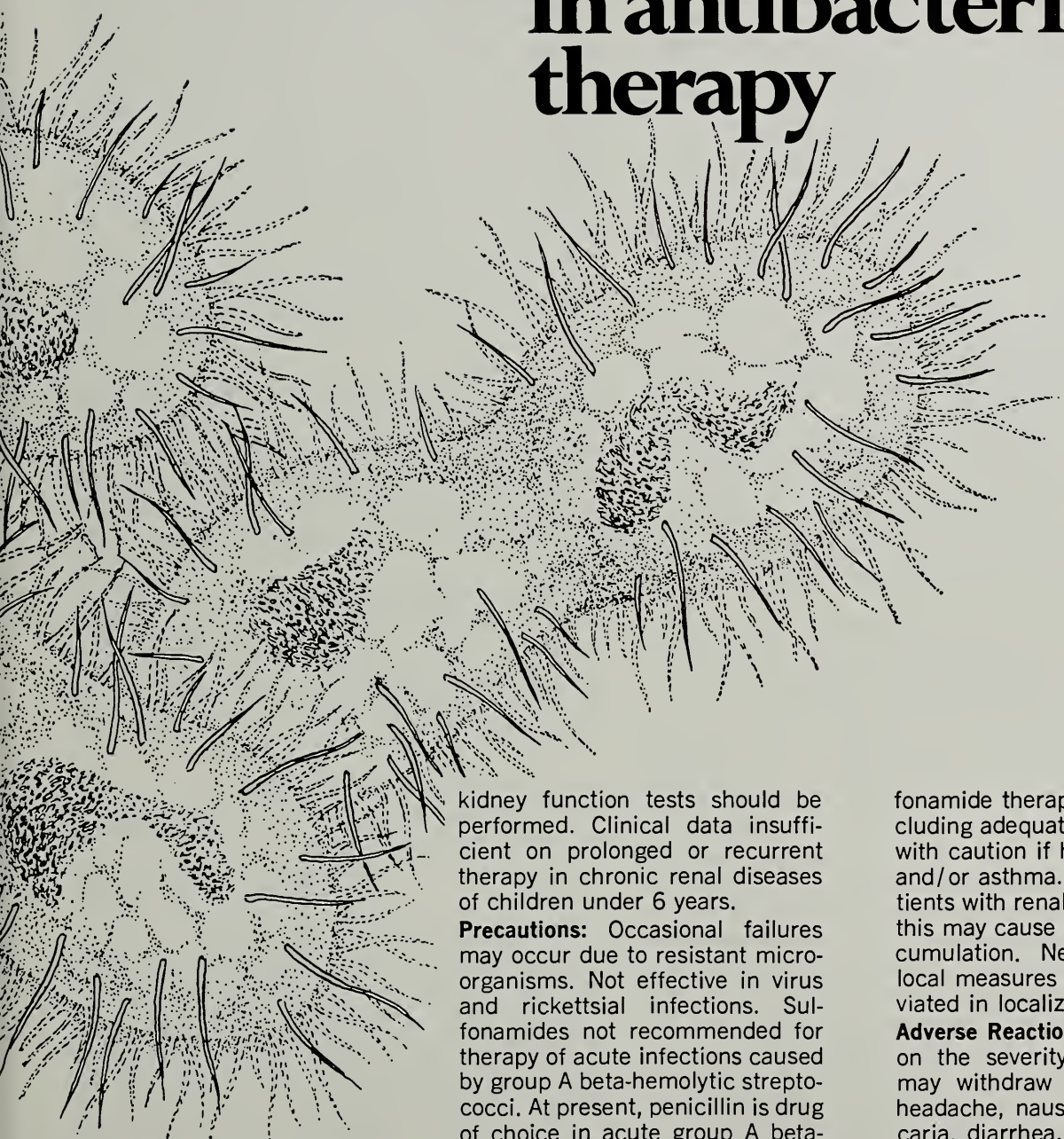
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Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days*. Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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ing themselves unreservedly to medical investigation and instruction, and with its own hospital in which the training of physicians and the healing of the sick harmoniously combine to the infinite advantage of both."

This is the concept of the team, perhaps not its beginning in medical education but certainly its beginning hallmark.

III

Sixty years later, Dr. John Millis and his colleagues brought out the Report of the Citizens Commission on Graduate Medical Education, and some have already compared it to Flexner's *Bulletin Number Four* for historical significance. Whereas Flexner examined the woeful inadequacies of 162 institutions claiming to be medical schools, Millis faced the task of fitting individual to knowledge. His commission sought three general objectives:

—A determination of the various kinds of medical careers necessary to provide society with medical services of a quality limited only by available knowledge.

—A definition of the general and specific characteristics of educational programs which will most effectively provide medical school graduates with the competencies necessary for these professional careers which should produce the ideal design of graduate educational programs in medicine.

—A proposal for modifying or otherwise altering existing programs so that they may approach or attain the ideal as quickly as possible.

Millis recognized one painful lesion on the body of progress, specialization. His commission quickly conceded that no physician can possibly possess all medical knowledge, and this clearly implies a division of specialization. But he was just as quick to say that the patient is undivided and that programs of education must give increasing emphasis to training physicians for cooperative effort. In short, the patient must have the combination of skills and knowledge best adapted to his particular medical needs.

Noting with regret that the total of American physicians who classify themselves as general practitioners had declined from 84 per cent in 1931 to 37 per cent in 1965, Millis said that "the general practitioner leaves behind him a vacuum that organized medicine has not decided how to fill."

But the commission could not foresee approval of the American Board of Family Practice three years in the future, and in this milestone, there is a whole new structure to assist the fulfillment of the commission's findings. When and if the institution of American medical education establishes sound curricula for the family physician envisioned in the concept of the new certifying board, there will be a new breed of doctor on the scene with the coordinating skills the commission was talking about.

IV

It is unfair to say that medical education has gone from rags to riches in 60 years only to arrive at poverty of success. But there are problems of the knowledge explosion and the pyramiding fund of all there is to know. Clearly, the answer is continuing medical education, and it's got to be a serious effort. The day may be fast approaching when the concept of the annual session and the medical convention are as radically altered as medicine's formal institutions of learning.

We are at the threshold of dividing business and learning at state, regional, and national medical organization levels. The scientific effort of tomorrow will be on-campus in the university center; the House of Delegates will meet at another place on another day. The alumni reunions, golf tournaments, and social occasions will be separated from the Scientific Assembly with a time and place for each. As a matter of fact, the business of medicine is becoming more demanding, too.

We no longer have to make a case for continuing medical education. Our real task is to think big enough to get on with the job. It's the only way we can assure the June medical graduate of 1969 that he will not be obsolete in 1980. —R.B.K.

Home Health Dilemma: Underutilization

With all the comment about overuse of medical care programs, it's a change of pace, to say the least, to hear the government complain because one isn't being used enough. This is the story of home health agency services under Medicare. In Mississippi, the program is being virtually ignored in some counties.

HEW officials in a recent visit to the state said that not a single referral has been made to some programs which have full participation approval. Of the 40-odd home health agencies approved under Medicare, all but two are centered in county public health departments. Usually, these in-

clude visiting nurse services and one other home health service, such as physical therapy. Two programs are based in community hospitals and are said to be doing a laudable job.

The idea of home health services is to offer care in the patient home environment, making further hospitalization or nursing home services unnecessary. Where a patient requires only a couple of visits weekly for injections or perhaps a session of physical therapy, the agency concept can be a convenience to patient and physician. It is important, however, that all such services be precisely prescribed by the attending physician and the patient's response and progress carefully monitored.

Where, in the opinion of the attending physician, the patient's medical needs are appropriately served in home care, then the medical facilities utilization crunch is eased. As the agency services gain experience and recruit skilled allied professional personnel, the concept will grow in importance as a patient care benefit.—R.B.K.

Medicaid's Unholy Image

Medicaid is getting itself an unholy image which it really doesn't deserve. Far from being a success story, the program is more likely to conjure up visions of fat cat profiteers and political mismanagement than care of those who demonstrably need help. This is unfortunate, and much must be done if the ideals of the legislation are to become institutionalized.

As with nearly every tax-assisted medical care program, Medicaid was underestimated. The Congress had to ante up more money than the fiscal forecasts sought. A few states achieved new highs in structural incompetence and inept administration: New York's $9,000 income eligibility ceiling, Kentucky's boondoggling, New Mexico's bankruptcy, and almost every state's scratching for money with which to sustain the program.

There will always be exceptions, but when respected national periodicals front-page a small town pharmacist billing Medicaid for $500,000 in one year with patients receiving as many as 30 prescriptions in a month, the situation deserves a second look. Under the same program, a dentist billed $54,000 in a year, and a number of physicians were said to have had equal charge volumes.

What doesn't make the headlines are the successes where tens of thousands of physicians and allied professionals render quality care to eligible beneficiaries for reasonable, usual charges. It's not news when a state enacts a sensible, sound program with appropriate medical orientation and a searching means test to make certain that public dollars are expended for demonstrated need.

These relatively infrequent exceptions are drawing the interest and attention of state governments about to enact Medicaid, and this could produce rigid programs which circumscribe providers and limit needed services. There is speculation about a Mississippi program with benefits spelled out in the law and line-item appropriations. This would be disasterous, placing the state in the posture of having to amend the law every time a federal regulation was changed. With line-item appropriations, it is entirely possible for the hospitalization fund to go busted with ample money in the medical service bank.

The central idea in Title XIX Medicaid is to have the states determine for themselves what health services are needed and shall be rendered. Where the system is weak and uncertain, the central concept goes out the window. All of this is to say that the infrequent abuse in Medicaid must be promptly cleaned up and the whole enterprise put on a business basis as a medical program. There are already too many established boondoggles in public works, agriculture, and transportation. The patient can't afford to settle for less, and an enlightened profession won't, either. —R.B.K.

Kudos for the College

The latest official listing of approved cancer programs by the American College of Surgeons shows a determined continuation of highest quality in standards and performance demand. The College states that the goal of the approval program "is a coordinated cancer activities program anchored to a systematized cancer registry in every hospital."

The statement continues by explaining that "experience has shown that without a registry, follow-up of the cancer patient is poor, educational information is lost, conclusions as to end results of therapy are erroneous, and the patient is ultimately the loser." The listings shows 890 approved cancer programs as a result of the College's 1968 inspections and surveys.

Mississippi has five with two at Jackson, one at Vicksburg, and two on the Gulf Coast at Gulfport and Biloxi. Of the five approved programs, one is in a state hospital, the University Medical Center; two are in federal medical institutions, the Jackson VA Center and the USAF Hospital at Keesler Air Force Base; and two are in community hospital centers, the Mercy Hospital-Street Me-

morial at Vicksburg and the Memorial Hospital at Gulfport.

The standards are exacting, so much so that not every medical institution can qualify for approval. This is consistent with the emphasis on the quality of care which the College has continually stressed. But the goal of professional education is not lost, and it is to the credit of the program nationally that this goal is pursued.

The cancer program approval activity is another vital service to medicine and the public which the American College of Surgeons performs. It is to be recalled with pride and satisfaction that the College instituted the hospital accreditation program which it has since handed over to the Joint Commission on Accreditation of Hospitals. The program merits support, and the qualified institutions have earned congratulations. —R.B.K.

DEATHS

BLACKWELDER, BRON-DEE, Quincy, Florida. M.D., Emory University School of Medicine, Atlanta, Georgia, 1915; certificate in Public Health, Johns Hopkins University School of Medicine, Baltimore, Maryland, 1931; post-graduate work in venereal diseases, Vanderbilt University School of Medicine, 1968; Tulane, 1944; State Board of Health, Obstetrics and Pediatrics, 1945; Emeritus member of MSMA; died Oct., 1968, aged 79.

CRUMBY, HOMER FLOYD, Woodland. M.D., Memphis Hospital Medical School, Memphis, Tennessee, 1912; interned Marine Hospital & St. Joseph Hospital, Memphis, one year; died May, 1968, aged 80.

HERRINGTON, JOSEPH CLARENCE, Rome. M.D., Memphis Hospital Medical College, Memphis, 1911; died Feb. 28, 1966, aged 86.

HOWARD, HOMER LAMAR, SR., Winona. M.D., University of Arkansas School of Medicine, Little Rock, 1932; interned Grady Memorial Hospital, Atlanta, Georgia, one year; died May 1, 1969, aged 63.

PERSONALS

EDWIN E. BENOIST of Natchez has been elected to the Fifty Year Club by the Board of Trustees of the state medical association. His certificate and lapel pin were presented at the recent meeting of his local society by Dr. Joseph B. Rogers of Oxford, association president.

THERESA L. R. BUCKLEY of Biloxi has been elected president of the coast city Altrusa Club. Dr. Buckley is a graduate of LeMoyne College and Marquette University and a former winner of the Woman of Achievement Award of the Business and Professional Women's Club of Biloxi. She limits her practice to ophthalmology.

O. WEIR CONNER, III, of Jackson has been named a Head Start Consultant by the American Academy of Pediatrics. AAP consultants evaluate the medical aspects of the program.

GAINES L. COOK of Grenada has been elected medical representative of the Grenada County Heart Association during the recent spring meeting of the organization. The unit raised about $2,500 during the 1969 Heart Fund campaign.

JAMES H. HENDRIX, JR., of Jackson has been elected president of the Southeastern Society of Plastic Surgeons. The society conducted its 1969 annual meeting at Hot Springs, Ark.

SAMUEL B. JOHNSON of Jackson recently addressed the North Jackson Lions Club on the provisions of Title XIX Medicaid. He outlined the six point positive program of the state medical association for implementation of the law in Mississippi.

CARL J. MORAN of Kiln has announced that he will open offices for practice at Fayette on July 1. A 1968 graduate of the University of Mississippi School of Medicine, Dr. Moran is completing his internship at St. Elizabeth Hospital, Dayton, Ohio.

A. N. MORPHY of Gulfport has retired as director of the Harrison County Health Department, a post he has held since 1950. He was honored by citizens of the county with a dinner at the Edgewater Gulf Hotel.

JAMES L. STITH of Pascagoula, president of the Jackson County Unit of the American Cancer Society, Mississippi Division, has announced an

educational campaign as a feature of the 1969 cancer crusade. He limits his practice to pathology.

C. D. Taylor, Jr., of Pass Christian has been elected president of the St. Paul's Mercy Carnival Association. The organization annually sponsors a carnival ball for the benefit of St. Paul's Catholic School. Dr. Taylor, a former king of the carnival, is the immediate past chairman of the state medical association's Board of Trustees.

NEW MEMBERS

The following physicians have been elected to membership by their respective component Medical Societies in the Mississippi State Medical Association and the American Medical Association.

Burrow, Nancy Watts, Brandon. Born Pelahatchie, Miss., Mar. 30, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned same, one year; radiology residency, same, July 1, 1964-June 30, 1967; elected Mar. 4, 1969 by Central Medical Society.

Maier, Alice Hull, Pascagoula. Born New Orleans, La., Sept. 23, 1936; M.D., Louisiana State University School of Medicine, 1962; interned Charity Hospital, New Orleans, La., one year; medicine residency and fellowship, Louisiana State University School of Medicine, New Orleans, July 1, 1963-June 30, 1966, excluding 6 months; elected Mar. 1, 1969 by Singing River Medical Society.

Maier, Findlay George, Pascagoula. Born New Orleans, La., July 6, 1936; M.D., Louisiana State University School of Medicine, 1962; interned Charity Hospital, New Orleans, La., one year; medicine residency, same, July 1, 1963-June 30, 1966; elected Mar. 1, 1969 by Singing River Medical Society.

Overby, James Allen, Meadville. Born Bruce, Miss., Dec. 23, 1933; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Mississippi Baptist Hospital, Jackson, one year; elected Feb. 4, 1969 by Homochitto Valley Medical Society.

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Purvis, Thomas Leo, Jr., Natchez. Born Jackson, Miss., Nov. 6, 1938; M.D., Louisiana State University School of Medicine, New Orleans, 1964; interned Confederate Memorial Medical Center, Shreveport, La., one year; Ob-Gyn residency, same, July 1, 1965-June 30, 1968; elected Feb. 1, 1969 by Homochitto Valley Medical Society.

Sinclair-Hall, Alvah H., Gulfport. Born Winnipeg, Canada, Dec. 25, 1905; M.D., University of Manitoba, Canada, 1930; interned St. Boniface Hospital, Winnipeg, Canada, June, 1929-June, 1932; residency, same, June, 1932-Sept., 1933; post-graduate studies, Mayo Clinic, Rochester, Minn., Sept., 1933-Dec., 1933; post-graduate studies, United Kingdom Royal Infirmary, Edinburg, 1936-1938; elected Feb. 5, 1969 by Coast Counties Medical Society.

Sykes, Henry Harvey, Jr., Gulfport. Born Grenada, Miss., Mar. 20, 1928; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned same, one year; pathology residency, same, July 1, 1964-June 30, 1968; elected Mar. 5, 1969 by Coast Counties Medical Society.

Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tympanic membrane is perforated) and otitis externa both respond to the bactericidal action of Furacin® (nitrofurazone) in Furacin-HC (nitrofurazone-hydrocortisone) Otic. Its broad antibacterial spectrum includes most of the organisms encountered in surface infections (but only certain strains of Pseudomonas). The hydrocortisone component in Furacin-HC Otic affords rapid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble base of Furacin-HC Otic permits free drainage and provides a hygroscopic vehicle.

Designed to please and protect the patient

Topical Furacin-HC Otic lets you reserve systemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal of cerumen.

Also available: Furocin® Otic (nitrofurazone with nifuroxime and diperodon HCl). The wide antibacteriol range of Furocin is augmented by the antimycotic activity of Micofur® (nifuroxime). Diperodon hydrochloride, an efficient local anesthetic, promptly subdues pain and itching. Indicated in bacteriol otitis externo, otomycosis or bacteriol otitis medio (when the eardrum is perforated).

Precautions: Sensitization to nitrofurazone may occur with prolonged use and is more likely to develop in eczematous otitis externo. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Contraindications: The usual contraindications for preparations containing hydrocortisone should be observed, such as tuberculous lesions of skin or ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand of nitrofurazone, and 1.0% hydrocortisone acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrofurazone, 0.375% Micofur®, brand of nifuroxime, and 2% diperodon hydrochloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.

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Dr. Royals Is Inaugurated President; Dr. Brumby Is Named President-elect

Dr. Paul B. Brumby of Lexington was named president-elect of the Mississippi State Medical Association at the 101st Annual Session, and Dr. James L. Royals of Jackson was inaugurated 1969-1970 president, succeeding Dr. Joseph B. Rogers of Oxford.

Fourteen specialty societies met concurrently with the Scientific Assembly before which a total of 55 essayists appeared. The technical and scientific exhibits were among the largest ever presented.

Scene of the meeting was the Buena Vista hotel and motel at Biloxi. Registration totaled 924 with 411 members, 92 physician-guests, 242 members of the Woman's Auxiliary, 165 exhibitors and other guests, and 14 staff.

A busy House of Delegates acted on 23 reports and nine resolutions in two meetings. Meanwhile, reference committees heard debate, comment, and suggestions leading to policy decisions.

In his address to the opening meeting of the House of Delegates, Dr. Rogers discussed physician-patient relationships with emphasis on third-party problems, recommending a program of individual responsibility of patient to physician.



Three years of the presidency stand still in time as 1968 President Joseph B. Rogers, right, gives the gavel to 1969 President James L. Royals, center. President-elect Paul B. Brumby, left, will serve in 1970.



Addressing the delegates after election, President-elect Brumby is surrounded by, from left, Speaker William E. Lotterhos, President Royals, and Secretary-Treasurer Walter H. Simmons.

Inviting attention to the rising costs of hospitalization, he said that "there are many procedures that can be done more quickly and economically in the office than in the hospital or emergency room. Over-utilization of hospitals in all its forms adds tremendously to medical costs and we should work diligently to keep these costs down.

"Many other opportunities to reduce costs without reducing quality of care will occur to many of you," Dr. Rogers said. "Let us put them into practice."

He called for incentives in the training of needed medical manpower, and he explained pressures of mounting medical demands by care consumers.

Dr. Rogers said that the contributions of the American Medical Association in medical education have been notable, and he praised AMA-ERF for voluntary support of medical schools.

The president said that "we have long agreed

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

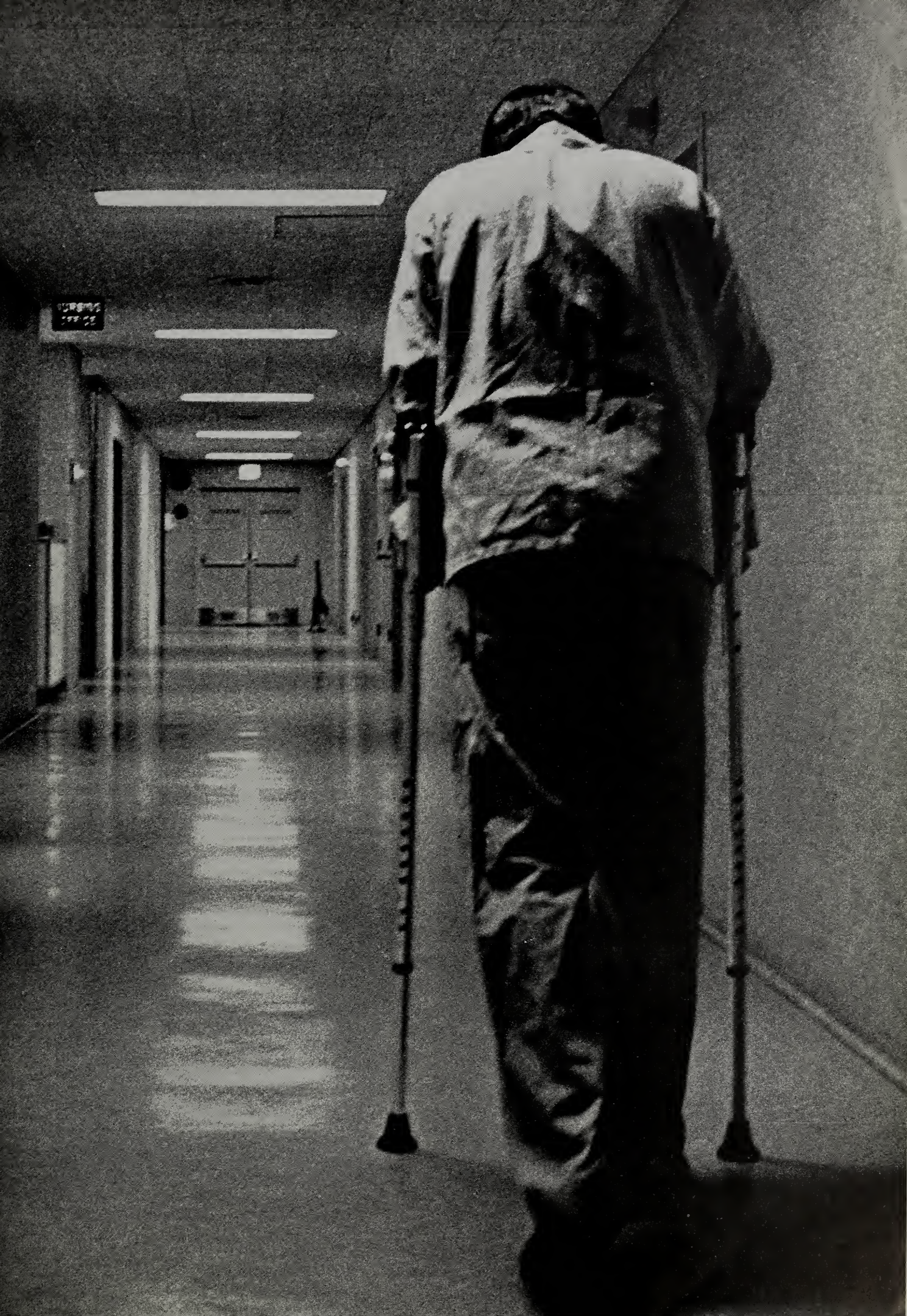
Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

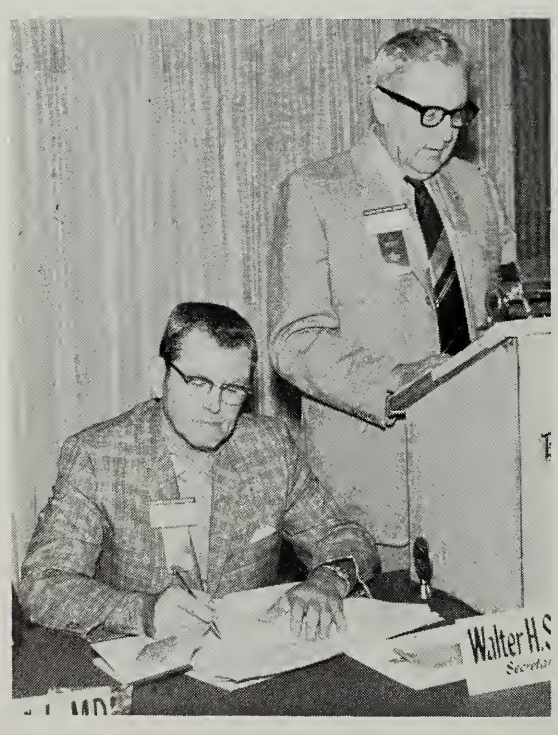
Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





Members of the Fifty Year Club are honored at the annual luncheon. Center at head are Cindy Sanders of MSMA staff who is secretary of club and Board of Trustees Chairman C. D. Taylor, Jr. Lower left, Dr. Walter H. Simmons keeps close check as Nominating Committee Chairman James T. Thompson presents slate. Lower right, Dr. Curtis W. Caine receives special AMA plaque for distinguished service in Viet Nam volunteer program from President Rogers.







Speaker Lotterhos presides over House of Delegates as Vice Speaker John B. Howell, Jr., finds a match for his pipe without losing a line. Right,



Board Chairman Taylor administers oath of office to President Royals as Executive Secretary Rowland B. Kennedy holds historic association Bible.

that we ought to face up to the fragmented programs of care for the indigent in our state which are inadequate, inequitable, and overlapping." He called the association's participation in comprehensive health planning "the achievement of 1968-69."

Also appearing before the House of Delegates was Dr. John M. Chenault of Decatur, Ala., AMA trustee and physician-husband of the AMA Auxiliary president.

Through the Committee on AMA-ERF, a check for $12,100 was presented to the University of Mississippi School of Medicine.

New vice presidents are Drs. G. Leroy Howell of Starkville, J. Dan Mitchell of Jackson, and Jack A. Atkinson of Brookhaven.

Re-elected to key posts on the JOURNAL were Drs. W. Moncure Dabney of Crystal Springs as editor and Thomas W. Wesson of Tupelo as associate editor.

Dr. G. Swink Hicks of Natchez was named to his second term as delegate to AMA, and Past President Rogers was named alternate delegate.

A new Trustee, Dr. James T. Thompson of Moss Point, was elected to succeed Dr. C. D. Taylor, Jr., of Pass Christian, former chairman of the Board, who retired after serving the constitutional maximum. Re-elected to Trustee posts were Drs. W. E. Moak of Richton and Everett Crawford of Tylertown.

Other elected and re-elected officials were Drs. George D. Purvis of Jackson, Council on Budget and Finance; Tom H. Mitchell of Vicksburg, Council on Constitution and By-Laws; and Dennis E. Ward of Corinth, Council on Medical Education.

Named also to councils were Drs. A. T. Tatum of Petal, David L. Clippinger of Hazlehurst, and C. D. Taylor, Jr., of Pass Christian, to the Council on Legislation; and Drs. Arthur A. Derrick, Jr., of Durant, William B. Wiener of Jackson, and Charles M. Moore of Philadelphia, to the Judicial Council.

Members of the Council on Medical Service named were Drs. John F. Lucas, Jr., of Greenwood, James O. Gilmore of Oxford, and Jack A. Stokes of Pontotoc.

Three seats on the State Board of Health will be open at the end of the year, and the House of Delegates nominated three physicians for each post to Gov. John Bell Williams. Drs. G. Lacey Biles of Sumner, Julian C. Bramlett of Oxford, and John R. Lovelace of Batesville were nominated for the Public Health District 2 seat.

Named to the Governor for Public Health District 4 were Drs. S. Lamar Bailey of Kosciusko, Lester D. Webb of Calhoun City, and Thomas N. Braddock, Jr., of West Point.

For the Public Health District 5 seat, the House nominated Drs. Lamar Arrington of Meridian, Omar Simmons of Newton, and John R. Laird of Union.

Busy Delegates Handle Big Agenda

A record agenda of 23 reports and nine resolutions made for a busy House of Delegates at the 101st Annual Session. The Board of Trustees, emerging from a year of intensive activity, submitted 10 reports to the delegates.

Principal items of business included Blue Shield, comprehensive health planning, nurse ed-

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochloride
In depression...
when words are not enough

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

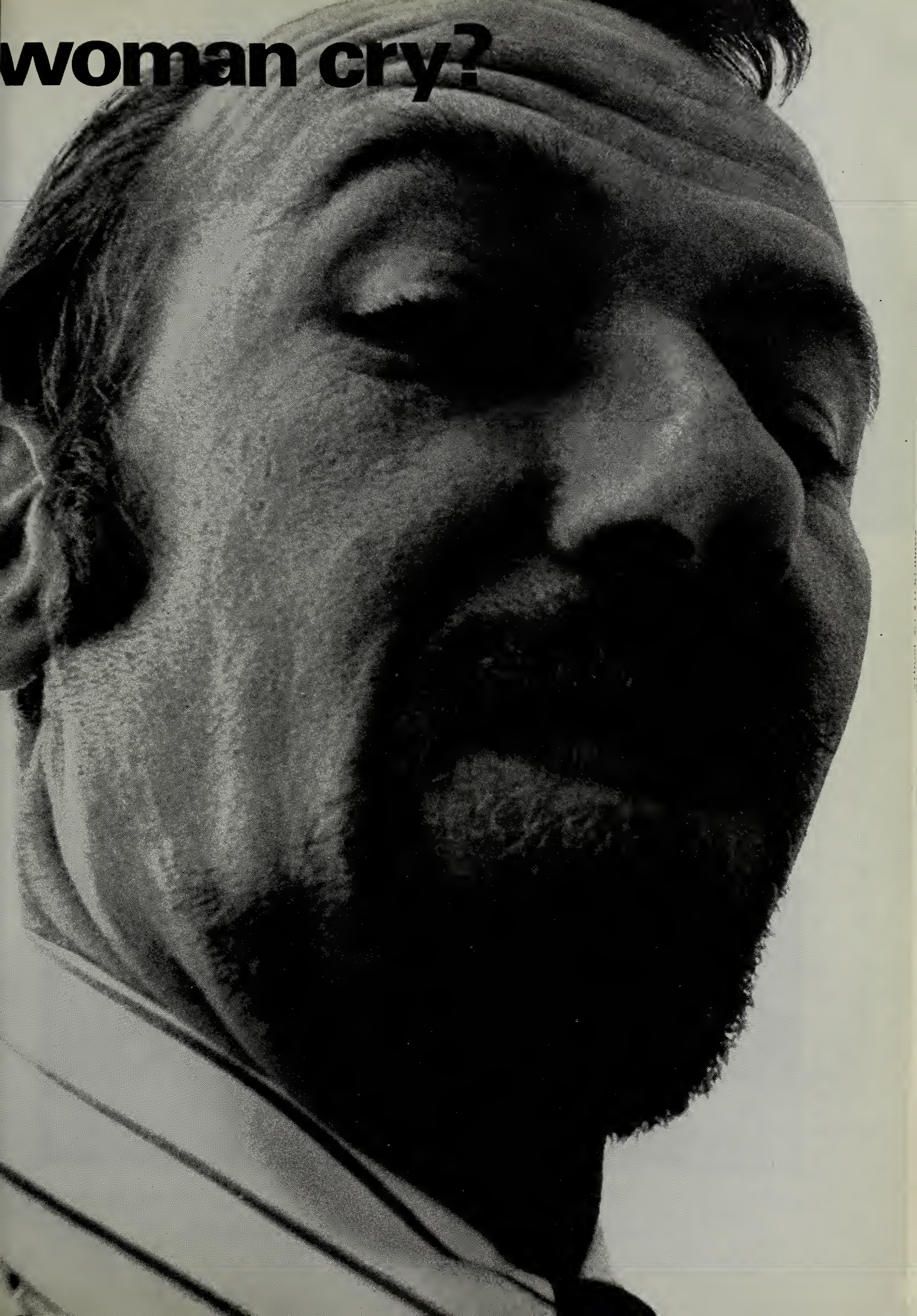
Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

woman cry?





Lovely ladies of Auxiliary are, seated, Mesdames Louis C. Lehmann, president; John M. Chenault of Decatur, Ala., AMA Auxiliary president, and Paul B. Brumby, past president. Standing are Mesdames T. E. Ross, III, first vice president; Lowry Rush, Jr., second vice president; Steve Sekul, third vice president; Robert C. Tibbs, secretary; and Curtis W. Caine, president-elect. Lower left, unique perhaps in all of medicine are huband-wife delegates, Drs. Mary and Dennis Ward. Right, Drs. Howell and Royals are absorbed in duties of House of Delegates.





The first Medihaler was developed for the physician-inventor's own child.

The improved model you prescribe today is still made with the same painstaking devotion.

When your patient is in the grip of bronchospasm and reaches for his Medihaler, it must work. Not sometimes. Not most of the time. *Always.*

This is the ideal of perfection which has motivated the constant process of improvement of Riker's Medihaler.

Since its invention in 1956—when a Riker physician developed the Medihaler because of his determination to make better treatment available for his own asthmatic child—Riker has pioneered just about every significant forward step in bronchodilator aerosol therapy.

Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

Riker was first to formulate medication in a non-irritating, non-alcoholic vehicle.

Riker pioneered pre-grinding of the medication to 1-5 micron size, assuring maximum distribution to the distal bronchioles for greater topical effectiveness with less systemic action. (Oddly, even today not all competitors have adopted these two advances.)

Add to these advantages a quality control system involving 168 physical measurements and chemical tests, plus not one but two test firings on every single unit leaving the plant, and you can readily see why there is no more dependable relief for bronchospasm than your prescription for Duo-Medihaler or Medihaler-Iso.

Please see next page for complete prescribing information.

Medihaler-Iso®
(isoproterenol sulfate)



Duo-Medihaler®
isoproterenol HCl (4mg./cc.)
phenylephrine bitartrate (6mg./cc.)

Riker Laboratories, Northridge, California 91324

The Riker Representative in your area is: Dalton Johnson

SUMMARY OF PRESCRIBING INFORMATION

DUO-MEDIHALER®

(isoproterenol hydrochloride and phenylephrine bitartrate)

Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Northridge, Calif. 91324

ucation and licensure, the headquarters building addition, insurance disclosure to hospitals, laboratory advertising, and charges by hospitals for medical services.

A host of other actions was taken by the House on the resolutions and reports, many of which contained several separate proposals.

The House of Delegates approved and endorsed the position of the Board of Trustees on Blue Shield, upholding and reaffirming the 1968 action when the association withdrew its approval of the Mississippi Hospital and Medical Service as a Blue Shield plan. But the House also endorsed the Board's open-door policy and expression of willingness to confer and negotiate with the plan at any time.

In its report, the Board noted that some progress has been made by the plan toward the six points approved by the House of Delegates on improving Blue Shield in Mississippi.

Under a change in the by-laws of the National Association of Blue Shield Plans, the approval of medical societies is necessary for a Blue Shield plan. The state medical association's position is to continue negotiation and conference toward the end of realizing improvements in the Mississippi plan.

The delegates declined to urge the state to cease accreditation of additional associate degree nursing programs in view of the nurse shortage, but they called for improving the quality of instruction in the programs.

A masters degree nurse program at the University Medical Center and other institutions of higher learning was supported, and strong emphasis was placed on nurse recruitment.

The addition to the headquarters building, previously approved by the House of Delegates, received support, and the House asked that "the addition be completed as soon as possible to fill the need for this additional space."

Physicians were warned against disclosure of professional liability insurance to hospitals and were advised that such requests by hospitals were an unwarranted invasion of their rights. The matter arose out of a Mississippi hospital requiring disclosure of professional liability coverage as a precondition to staff membership and privileges.

Industrial laboratory advertising and solicitation of physicians to consult with industrial laboratories was said by the House "not in keeping with good medical practices and that physician-to-physician consultation should not be replaced with physician-to-industrial-concern consultation."

The association will introduce the resolution before the AMA House of Delegates at New



Reference committee chairman Jack A. Adkinson reports to House of Delegates. Left, Dr. James T. Thompson receives congratulations from Dr. C. D.



Taylor, Jr., as new District 9 Trustee. Dr. Taylor retired from Board after serving constitutional maximum.

York in July. Crux of the matter is acceptance of industrial laboratory advertising by the *Journal of the American Medical Association.*

A resolution reaffirming the association's belief "that no hospital should sell the services of a physician" grew out of a circumstance where "at least one hospital in Mississippi appears to have made charges to patients for services rendered by house officers."

The action excluded "ethical and proper arrangements between hospitals and pathologists and hospitals and radiologists or ethical and proper arrangements made for emergency medical services in hospitals."

The House received a report that the association had been named a defendant in a suit filed in chancery court in Forrest County, also against the American Medical Association. Other defendants named included the South Mississippi Medical Society, two officers of the society, and Rowland B. Kennedy, state association executive secretary.

It was reported to the House of Delegates that the plaintiff in the suit is Dr. J. P. Culpepper, Jr., of Hattiesburg.

In other actions, the House of Delegates:

—Urged enactment of a state law which would require at least two physicians as voting members of every county, county-city, or city hospital governing board.

—Applauded a report that membership has increased.

—Amended the charter of the former Homochitto Valley Medical Society, redesignating it the Adams County Medical Society.

—Expressed gratification over organization of the Mississippi Postgraduate Institute in the Medical Sciences as a joint venture of the University Medical Center and the association.

—Reserved judgment on the Delta-HEW project which will provide expanded public health services, allied professional personnel training, and a limited vendor medical program for a five county area.

—Rescheduled the annual session dates after 1970 so as to avoid conflicts with Mother's Day and municipal elections on years conducted.

—Adopted a policy stating that every Mississippi woman should have an annual Pap smear and supported a program to seek irradication of pelvic cancer.

—Fixed responsibility for emergency medical services on the medical profession in each community of the state.

—Approved participation of the association in a second series of utilization review conferences, the subject of the series to be extended care facilities.

—Concurred in opinions by the Judicial Council on transplants, drug share ownership, compulsory staff assessments, telephone directory listings, laboratory services, bank credit cards, and on condemnation of treatment of obesity by "rainbow pill" regimen.

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

—Requested MPAC to prepare educational materials on duties of coroners for physicians and to assist physician-candidates who seek the office.

—Sought more adequate professional compensation for autopsy.

—Called for relief from harassment by litigation against physicians summoned to examine patients for commitment to mental institutions.

—Agreed to support enactment of a law permitting all physicians to form professional corporations.

—Disapproved proposals for the speaker and vice speaker to be *ex officio* members of the Board of Trustees and to appoint reference committees.

—Elevated the Committee on Blood and Blood Banking to constitutional status.

—Announced that a dues increase would be presented in 1970 to become effective in 1971.



Speaker Lotterhos presents Auxiliary leaders to delegates. Left is Mrs. Louis C. Lehmann, 1969-70 president, and right is Mrs. Paul B. Brumby, 1968-69 president.

Board of Trustees Names New Officers

The nine-member governing body of the association, the Board of Trustees, has named Dr. Mal S. Riddell, Jr., of Winona, District 4 Trustee, as its 1969-70 chairman. Dr. J. T. Davis of Corinth, District 2, was re-elected vice chairman.

Dr. William O. Barnett of Jackson is the Board's new secretary. He, the chairman, and vice chairman make up the executive committee.

Retiring from the Board as senior member and chairman was Dr. C. D. Taylor, Jr., of Pass Christian who had served the constitutional maximum. Succeeding Dr. Taylor as District 9 Trustee is Dr. James T. Thompson of Moss Point.

Drs. W. E. Moak of Richton, District 7, and Everett Crawford of Tylertown, District 8, were re-elected to full terms.

Continuing to serve current terms are Drs. John A. Alford, Jr., of Greenwood, District 1, James O. Gilmore of Oxford, District 2, and Guy T. Vise of Meridian, District 6.

Seven general officers meet with the Board regularly but without the right to vote. They are the president, president-elect, secretary-treasurer, speaker, vice speaker, and AMA delegates.

Dr. Rogers Is New AMA Alternate Delegate

Dr. Joseph B. Rogers of Oxford, immediate past president of the association, was appointed to serve the unexpired term of the late Dr. B. B. O'Mara of Biloxi as alternate delegate to AMA. The appointment was made by President James L. Royals of Jackson.

Dr. O'Mara died suddenly on May 24. He was 1948 president of the association and was serving as alternate delegate to Dr. G. Swink Hicks of Natchez, AMA delegate.

Dr. Rogers was elected to a regular term as AMA alternate delegate at the 101st Annual Session, and he will take office on Jan. 1, 1970. The unexpired term to which he was appointed runs until Dec. 31, 1969.

Scientific Assembly Begins Work for '70

The 102nd Annual Session? In 1970?

It's already in the planning stages on the drawing board of the Council on Scientific Assembly. The dates are May 11-14, 1970, with headquarters at the Buena Vista hotel and motel at Biloxi.

Acting by separate sections during the recent 101st Annual Session, the seven components of the Scientific Assembly named new chairmen, and two sections elected new secretaries. Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years. Each office carries an automatic

seat and vote in the House of Delegates to assure proper representation of each scientific section.

Secretaries of the seven sections are on staggered terms so that annual elections are for two, two, and three in any three-year period.

Named to head the Section on EENT is Dr. James L. Pettis, Jr., of Tupelo, while Dr. James K. Williams, Jr., of Pascagoula continues to serve as section secretary.

Heading the Section on General Practice is Dr. W. H. Parker of Heidelberg. Dr. W. Johnson Witt of Jackson remains at his post as secretary.

The internists chose Dr. Ben P. Folk, Jr., of Jackson as chairman of the Section on Medicine. Dr. C. Ralph Daniel, Jr., enters his third year as section secretary.

Advancing from secretary to chairman, Dr. J. Purves McLaurin of Oxford heads the Section on Obstetrics and Gynecology. Named to the post of secretary for a three-year term is Dr. Warren Plauche of Biloxi.

Dr. W. J. Carr, Jr., of Gulfport is the new chairman of the Section on Pediatrics. Continuing at his post as secretary is Dr. William F. Sistrunk of Jackson.

A new slate of officers leads the Section on Preventive Medicine with Dr. Frank J. Morgan, Jr., of Jackson, serving as chairman and Dr. F. K. Tatum of Tupelo at the post of secretary.

Rounding out the seven section assembly in the Section on Surgery are Dr. W. Coupery Shands of Jackson, chairman, and Dr. M. Beckett Howorth of Oxford who begins his third year as a section officer.

Dr. Walter H. Simmons of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly.

Dr. Simmons said that "the council will be meeting this summer to review preliminary plans for the 102nd Annual Session and to begin actively working on the program."

He said that the exhibit prospectus for technical exhibitors will be released in the fall. Specialty societies are invited to submit plans for concurrent meetings and requests for assignment of rooms, including those for meal occasions, he added.

The president, Dr. James L. Royals of Jackson, and the president-elect, Dr. Paul B. Brumby of Lexington, are *ex officio* members of the Council on Scientific Assembly under the By-Laws.



Dr. Omar Simmons receives 1969 MSMA-Robins Award from President Rogers as Hiram Stewart of A. H. Robins Co., left, assists. Right, Dr. Simmons



congratulates Dr. Henry B. Tyler, who with Dr. Albert L. Meena, won $500 Aesculapius Award for best scientific exhibit by a member.

Robert Pearson Named Field Sales Manager

Robert D. Pearson has been appointed field sales manager at Wyeth Laboratories, reporting to D. O. Wilson, director of sales. The promotion was announced by L. J. Hymel, vice president for sales and promotion.

Mr. Pearson, a graduate of the University of Massachusetts, joined Wyeth's sales force in 1947 as a territory manager in Baltimore, and in 1951 was appointed district sales manager in Washington. Since 1963 he has been divisional sales manager for Pennsylvania, Delaware and southern New Jersey, with headquarters in Wilmington, Del.

AMA Gets Award For Speakers Program

The American Medical Association's Speakers Program has been awarded a Golden Trumpet Award in competition sponsored by the Publicity Club of Chicago. The award cites the Speakers Program as the best public relations special program conducted by a non-profit organization during the past year.

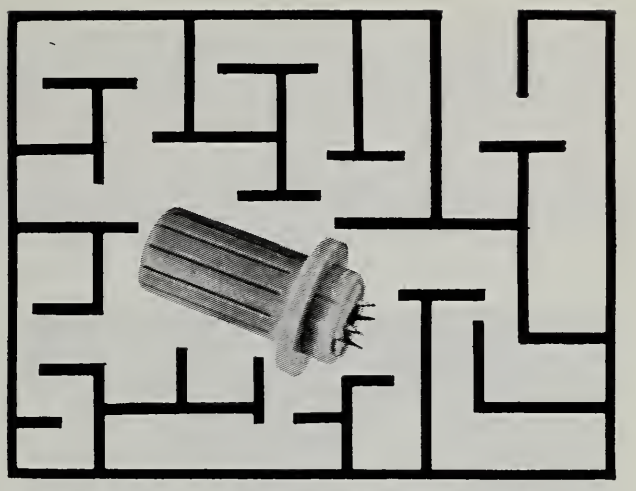
Since the Speakers Program was initiated in March 1967, 1,500 physicians have been trained as public speakers in 38 seminars conducted around the country by AMA staff. The program also includes placement of physician speakers who are experts in various health and medical subjects.

Delta MAMA's Name Medical Advisers

Dr. John D. Wofford of Greenwood has been elected to succeed himself as medical adviser to the Delta Chapter of the Mississippi Association of Medical Assistants. Other advisers continuing to serve are Drs. Howard A. Nelson, Richard Flowers, and Guy P. Sharpe of Greenwood and Dr. Ben P. Evans of Grenada.

Dr. Wofford has also been named to serve a second year on the state advisory body to the association, and Dr. Flowers was elected to a two year term.

The Mississippi Association of Medical Assistants carries the approval of the state medical association. The organization is primarily an educational vehicle for medical assistants who seek refinement of skills in office and clinic administration and specialized work relating to medical practice.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

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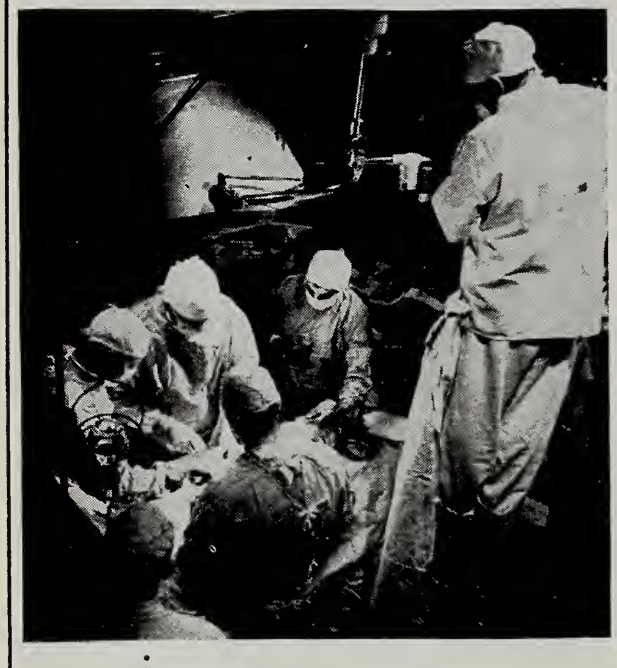
Protests Mount Over Fee Freeze

Mississippi physicians are becoming increasingly concerned over the Medicare profile freeze and the moratorium on fee revisions invoked by the Social Security Administration. Calls about disputed claims with the Part 1-B carrier have notably mounted, spokesmen said.

Chief complaints received revolve about pegging usual and customary fees at low points recorded for individual physicians. Association officials said that Medicare profiles relate to the individual practitioner by personal identity and not to a geographic area which would disclose a range of fees.

One south Mississippi physician reported making a charge of $3 for a minor office service to a

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Medicare beneficiary, only to have a claim for his usual office visit fee of $5 subsequently rejected "because the profile shows your office visit fee is $3," he told the association.

Another physician reported fee reductions without explanation when charges were made for several services. He said "we only want to know where we are high, if we are, and what portion of the total charge is being reduced."

The recent action of SSA placed severe restrictions on upward revision of physicians' charges, although no similar anchor was tied to hospital charges. Hospitals have, however, been denied capital depreciation allowances formerly permitted.

Dr. Mal S. Riddell, Jr., of Winona, chairman of the association's Health Insurance Benefits Advisory Committee, said that "the full range of SSA actions and its impact on medical practice in the state will be explored at our next meeting."

He said that the committee offers a forum for association representatives to confer face-to-face with Social Security Administration, HEW, and Part 1-B carrier representatives.

Physicians are invited, Dr. Riddell said, to submit documentation of unsatisfactory claim settlements under the over-65 program.

Mississippians Spark ACP Regional Meet

Twelve Mississippi physicians appeared on the program of the New Orleans regional meeting of the American College of Physicians last month. Dr. Wesley W. Lake, Sr., of Gulfport, ACP governor for Mississippi, presided at the opening session.

Jackson physicians appearing on the scientific program included Drs. James D. Hardy, Richard G. Hutchinson, Myra Tyler, Ben B. Johnson, Charles Sledge, Lois Mosey, and James Lewis, Jr.

Also appearing were Drs. E. Leonard Posey, Keith Boler, and Alvin E. Brent, Jr.

Program topics centered around the national coronary drug research project, effect of obesity in lung disease, and discussions of gastrointestinal, kidney, and cardiovascular conditions. Special guests for the regional meet were Dr. Samuel P. Asper of Baltimore, ACP president, and Dr. Edward C. Rosenow, Jr., of Philadelphia, ACP executive director.

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CONTENTS

ORIGINAL PAPERS

Cardiac Surgery in Infants **283** HILARY H. TIMMIS, M.D.; J. D. HARDY, M.D.; and DAVID G. WATSON, M.D.

SPECIAL ARTICLES

Day of Decision: Medicaid for Mississippi? **291** ROWLAND B. KENNEDY
Radiologic Seminar LXXXV: Ascariasis Demonstrated By a G.I. Series **296** CLYDE SMITH, M.D.
We Dare Not Do Less **298** JOSEPH B. ROGERS, M.D.
Constitution and By-Laws of the Mississippi State Medical Association **302** Annual Publication

EDITORIALS

Prescription Drug Substitution: Old Problem With New Faces **313** An Evil to All
Womanpower May Be The Answer **314** Bring on the Girls!
The Unspeakable Alternative to Medicaid **316** Consequences of Inaction
The Tight Dilemma of Hospital Costs **317** Up, Up, and Away
Well-Represented by Mr. Brown **317** Honors for the Journal

THIS MONTH

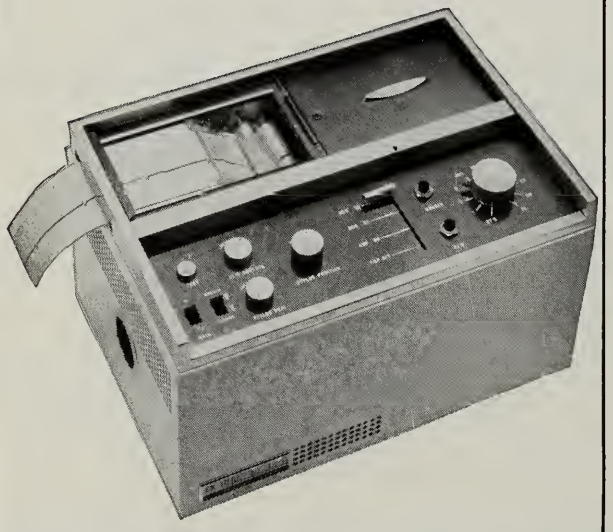
The President Speaking **312** Politics: Not a Dirty Word
Medical Organization **323** MSMA Headquarters Construction on New Addition Begins

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NIH Grant Awarded Nobel Laureate

The award of a five-year grant to Dr. James D. Watson, Nobel Laureate and pioneer in molecular biology, to establish a tumor virus research center on Long Island, N. Y., has been announced by the National Cancer Institute, National Institutes of Health. The center, to be located at the Cold Spring Harbor Laboratory of Quantitative Biology, will conduct genetic and biochemical studies of the tumor viruses SV-40 and polyoma.

Dr. Watson shared the 1962 Nobel Prize in Medicine and Physiology with Drs. Francis Crick and Maurice Wilkins for elucidating the structure of the nucleic acid molecule, DNA. The SV-40 and polyoma viruses are small DNA viruses capable of causing tumors in animals and changes in the appearance of tumor cells in laboratory culture. It is considered feasible, through genetic analysis, to learn what each of the viruses does, to discover the cause of malignancy.

Dr. Watson and associates will conduct several other lines of investigation including the synthesis of viral specific DNA, RNA, and protein, the role of temperature in DNA synthesis, and the integration of viral DNA into the host chromosome.

The Cold Spring Harbor Laboratory has been associated with many significant contributions to genetics and molecular biology, and the Federal research grant will initiate a new full-scale research effort of the first rank at the institution.

Humble's People Get Regular Health Exams

At Humble Oil and Refining Co., employees are encouraged to consult their personal physician for their company periodic health examinations, it was revealed at the annual meeting of the Industrial Medical Association in Houston, Tex.

Dr. V. C. Baird, Humble Medical Director, explained that the basic rationale behind the program is to promote a closer relationship between the individual employee and a physician who will be available for complete, as well as preventive medical care. This relationship is considered a valuable, but frequently overlooked aspect in the prevention of illness and disease, according to Dr. Baird, who added that all periodic health examinations that are *job-related* are performed by company, or company-selected physicians.

Approximately 2,500 industrial physicians, nurses and other health specialists attended the 4-day American Industrial Health Conference which is comprised of the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses.

Medical Leasing Shows Growth

Medical Leasing Corporation, one of the nation's leading lessors of medical and dental equipment to physicians, dentists and hospitals, announced a 540 per cent increase in earnings from 5-cents per share to 32-cents per share for the nine months ending April 30, 1969 over the same period last year.

Gross value of leases written in the same period increased 357 per cent from $516,273 in 1968 to $2,361,115 in 1969. Net income for the nine month period increased 648 per cent from $14,-567 in 1968 to $108,889 this year.

The average number of shares outstanding in the same period increased 5 per cent from 295,-500 in 1968 to 309,700 this year.

Gerson E. Lewis, president, said that purchases of franchised sales offices from Medical Leasing Corporation continued to increase and should add materially to the firm's lease volume in the future. "These sales offices are operated in exclusive marketing areas and are awarded only after certification by the company of successful completion of a full training program," Lewis said.

Commenting on the future, Lewis said "the advent of Medicare has brought an increasing demand from medical institutions and our leasing program of medical equipment to physicians has more than kept pace with our projections."

Lewis noted that "all of the business negotiated during the third quarter and prior periods of our current fiscal year was consummated before the receipt of proceeds from the recent offering and sale of our stock," which Lewis said has "'materially strengthened our borrowing capacity with major commercial banks throughout the U. S." He said this factor is of special significance at this time due to the current tight money situation.

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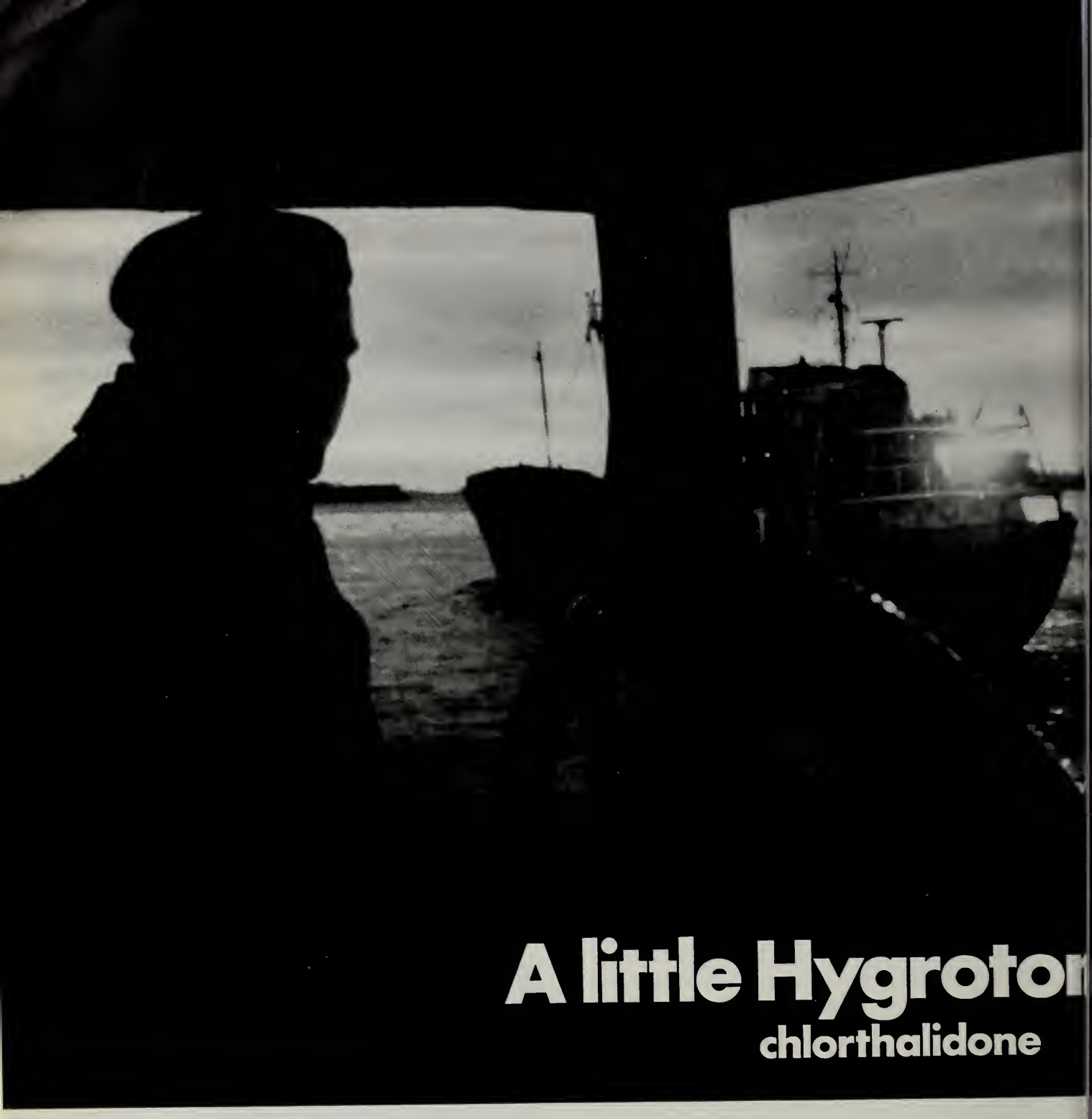
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION

JACKSON, MISSISSIPPI

July 1969

Dear Doctor:

Tupelo lost a major industry of questionable merit when narcotics agents seized 22 pounds of made-in-Mississippi methadone. Dr. James L. Harper, a research chemist with an Ole Miss degree, was arrested and said to be operating in conjunction with a Baltimore-based distributor. Illicit laboratory was openly located in an office building complex.

> Federal and state agents said that seizure was largest in history of the synthetic drug. Costs of manufacture were estimated to be only $150 per pound, but police believe that entire cache would have fetched $5 million on underworld markets.

Better wed than dead, according to the Health Insurance Institute which has just completed a study of longevity by marital state. Married men live notably longer than bachelors or those divorced. HII said while disparity in death rates continues throughout life, it peaks in the 30-to-44 age ranges. Study report says that divorced men register highest death rate at every age level.

Gov. John Bell Williams and selected staff will conduct seven regional meetings on Medicaid for legislators this month. Meeting series is reminescent of 1967-68 district informational sessions sponsored by MSMA. Purpose is orientation of lawmakers to difficult issues of Medicaid before special session.

Inexcusably wasteful medical manpower policies by the military services are forcing continuation of Doctor Draft. Recent study showed that 2,500 physicians out of 16,000 in military service are in administrative jobs. If non-M.D.'s were so assigned, Doctor Draft could be ended. There is virtually no prospect of changing law as long as U.S. is plagued with Viet Nam.

AMA continues to have red, white, and blue address for Washington office, more like a patriotic rather than a medical organization. Washington office is vacating crowded quarters at 1 Farragut Square to move this month to 1776 "K" St., NW.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

UMC Takes On Appalachia Health Study

Jackson - The Department of Preventive Medicine at UMC has contracted with the Division of Comprehensive Health Planning to perform a $50,000 study of the 20-county area of northeast Mississippi located in the depressed Appalachia region. Study will survey health care resources and evaluate needs for new and expanded health services and facilities. Objective is to qualify state for a federal health care grant of several million dollars.

Hill-Burton Extension Looms As Sure Thing

Washington - The House of Representatives gave the Hill-Burton program a 351-to-0 vote of confidence to extend it three years, double the federal funds, and shift priorities to cities over favored rural communities. Recent criticism of program centers around half-empty rural area hospitals as cities, with no priorities, are urgently in need of additional beds. Mississippi leads nation in percentage of gain in hospital beds and is in top half on ratio of beds to population.

Mississippi M.D.'s Are Among Biggest AMA-ERF Supporters

Chicago - UMC was among the top 10 medical schools in the nation in AMA-ERF gifts in 1968 with state physicians giving $10 for every AMA-ERF $1. Mississippi M.D.'s gave more than physicians in Alabama, Arkansas, Louisiana, and Tennessee gave to their respective schools. Worst record of the year goes to University of Massachusetts Medical School which got total of $45 from 4,000 physicians.

Court-Ordered Contraception Is Novel Legal Theory

New York - The American Bar Association Journal carried a unique paper recently suggesting that a juvenile court could order insertion of IUCD's in minors who have produced illegitimate pregnancies. Theory is based on power to order sterilization but advocates lesser measure of contraception as "requiring no cooperative action and no voluntary participation in using it effectively." Authors say account should be taken of possible side effects and medical advice. Reference is Am. Bar Assn. J. 55:223 (March) 1969.

Alabama Chiropractors Seek Liberalized Law

Montgomery - Give a cultist an inch, and he'll take a mile, so Alabama is finding out about chiropractors. Four chiropractic bills before legislature would cover gynecology, permit practice for a year before meeting licensure requirements, suspend rather than revoke licenses for infractions, and set up postgraduate work. Wherever cult is legalized, the spinepunchers go for more.

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Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering NORGESIC to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

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Grant Funds New Cancer Study

An experimental cancer treatment which combines drug therapy with deep body cooling will be developed at Emory University's medical school under a research grant of $88,916 from The John A. Hartford Foundation, Inc., of New York City.

The award for three years of studies was jointly announced by the Foundation's president Harry B. George and Dr. Arthur P. Richardson, dean of the medical school.

The work will be directed by Dr. Vojin Ponovic, Emory professor of physiology, who has achieved regression or complete disappearance of various malignancies by this method in laboratory experiments. Dr. Popovic expects that further experimental studies will lead to the first clinical use of the technique with human brain-tumor patients.

The Popovic method is based on what he terms "differential hypothermia" in which the body is cooled to about 40 to 45 degrees Fahrenheit while the tumor is maintained at normal temperature—98.6 degrees Fahrenheit. Then the anti-cancer drug 5-Fluorouracil is injected into the bloodstream. Blood flows to the warm tumor at a much greater rate than to the cooled tissues and metabolism in the tumor cells rises by as much as 500 per cent. Because of the refrigerated state of the rest of the body, the drug does not poison the healthy cells, the Emory physiologist explains, but vigorously attacks the cancerous ones.

His studies show that after an hour, the warm tumor has consumed most of the drug so that other tissue does not suffer from drug toxicity when rewarmed.

Special tumor-warming devices are being developed by a group of electronics engineers led by Dr. R. C. Johnson, head of the Electronics Division of the Engineering Experimental Station of Georgia Institute of Technology in Atlanta. Several electronic principles will be tested in these devices, including microwave and ultra-sound energy. The goal is to fashion precise mechanisms that will focus on a brain tumor and warm the malignancy while surrounding tissues stay cool.

The clinical trials with human cancer patients will be conducted by Dr. R. G. Selker, Emory associate professor of neurosurgery, in association with Dr. Popovic.

'Truth in Lending' May Affect M.D.s

The "Truth in Lending" law, officially the Consumer Credit Protection Act, will probably affect physicians. Enacted to become effective July 1, 1969, the law has as its purpose full disclosure of true and actual finance and interest charges.

The Federal Reserve Board, responsible agency for issuance of regulations relating to administration of law, says that it "applies to doctors, dentists, and other professional people and hospitals."

The chairman of the Federal Trade Commission, Paul Dixon Rand, said that anyone is affected by the legislation if any financing charge is made or if a debt is payable in more than four installments.

The AMA Judicial Council has ruled that it is unethical for a physician to charge interest on fees for professional services. Bank credit cards, however, when used for payment of medical bills, may bring the new law into play.

AMA reports that its Law Division is studying the new enactment, and spokesmen said that physicians are well-advised to familiarize themselves with the new regulations.

Medicine May Be Utility, Warns ASIM

The American medical profession "is nearing a confrontation and may soon become a public utility with all the accompanying regulations," the incoming president of the American Society of Internal Medicine warned at the annual meeting in Chicago.

That is, said Dr. Clyde C. Greene, Jr., of San Francisco, unless physicians become "very much more aware of the public's demands and expectations."

He said practicing physicians as well as physicians in hospital training, and, eventually, medical students, must become knowledgeable about not only delivering high-quality medical care, but about delivering it efficiently, as well.

In an interview prior to his installation as president, Dr. Greene pointed out that his society earlier in the day had approved a resolution to go on record and urge that the American Medical Association require the addition of social and economic subjects of medicine to the scientific subjects which are now part of medical curricula.

He said doctors are well-educated to deliver medical care, but receive little or no education in

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the actual practice of medicine. "They are expected to go out and practice yet they know nothing about running an office or buying equipment or evaluating the economic and social aspects of their practice," Dr. Greene said.

Expanding on his prepared text, he said that the American medical system must strive to remain flexible and not come under the rigid regulation of government. Such regulation would stifle medical progress.

If medicine becomes so regulated that it falls to the status of a utility, each new drug or other treatment or tool that came along would be subject to the review of endless governmental agencies, he said. As a result, few new innovations would become available, and some might even be held back for years, just as new technological developments by utilities are held back by governmental agencies, he said.

"Once the government decides that one form of digitalis (a heart drug) is the only one which can be used, for instance, you have eliminated the doctor's choice of medication and removed his flexibility in treating his patients," Dr. Greene said.

In his prepared text he said, "Revolutionary changes in the delivery of medical care are to be expected over the next several years. The health service industry is already the third largest in our country, and it will continue to grow. This is inevitable because society is approaching the concept of health as an individual's physical, mental, and social well-being—rather than as the absence of disease or infirmity."

He said that "The development of many new types of allied health personnel will furnish partial solutions. Automation, screening examinations, and the use of computers may also help meet the health care crisis which is partly resulting from the rising demand for the physician's services."

He said that the American Society of Internal Medicine must:

1. Represent internists, none of whom can avoid increasing involvement in the socio-economics of medical practice. He added that the emphasis will be more on the social aspects and less on the economic aspects.

2. Keep internists informed "about the ferment taking place in the financing and delivery of health care. They cannot be allowed to ignore what is going on in America at a time when our culture is riot-ridden and war-divided. They must be alerted to cure-all legislation aimed at eliminating such things as poverty, disease, crime.

3. Involve internists. "They must become involved with regional medical programs, comprehensive health planning, and other laws."

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Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

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Auxiliary Announces Youth Convention Program

Pre-teens and teenagers accompanying their parents to New York City for the American Medical Association annual convention, July 13-17, will find a program of exciting activities waiting just for them.

As in past years, the Woman's Auxiliary to the American Medical Association will offer supervised tours especially designed for young people. Separate day and evening programs are planned for pre-teens (ages 6 through 12) and teenagers.

Reservations for the programs must be made in advance with Seena Hamilton, Gulliver's Trails, 25 Central Park West, New York, N. Y. 10023. The name and home address of the parent, name and age of each child, and a check for the total amount must accompany each reservation.

Activities planned include Little Old New York, a boat trip to the Statue of Liberty, tour of the United Nations, lunch in Chinatown, tours of NBC studios, Lincoln Center, New York Philharmonic and New York Police Academy, Central Park Zoo and the Empire State Building. Visits to two Greenwich Village teen clubs are special attractions for the older group.

Teen headquarters will be the Regency Suite (4th floor), Waldorf-Astoria Hotel. Registration opens at 11:00 a.m. Sunday, July 13. Mrs. Albert Patrick and Mrs. Joseph F. Shanaphy, both of Staten Island, N. Y., are chairmen of the teenage program committee.

UMC Kidney Unit Grant Renewed

A $121,091 federal grant has been awarded the University of Mississippi Medical Center in Jackson for additional support of the Artificial Kidney Unit. Governor John Bell Williams announced the award and emphasized that the fund must be supplemented by voluntary contributions if dialysis is to be available to the more than 100 Mississippians now suffering from kidney failure.

The Artificial Kidney Unit, directed by Dr. John Bower, was originally established with a federal grant of three years' duration, expiring in 1969. Minimum cost of maintaining a patient is $10,000 per year.

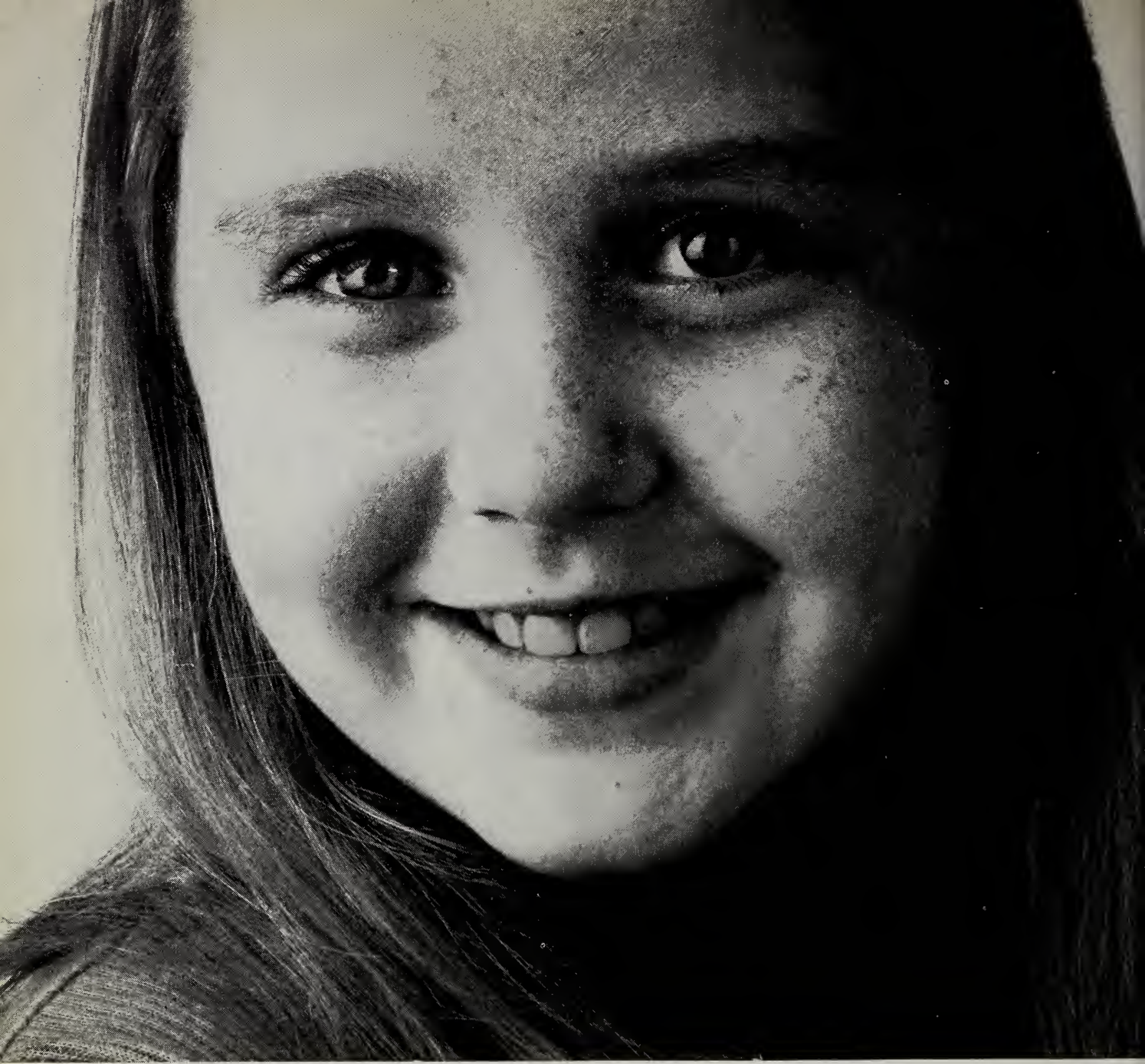


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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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ORIGINAL PAPERS

Cardiac Surgery in Infants

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Operation is mandatory during infancy in many instances of congenital cardiac lesions both as a lifesaving measure as well as to accommodate satisfactory growth and development. The authors discuss a series of 112 children below 2 years of age who were operated on for congenital heart disease at the University Hospital. They describe the cardiac lesions, the indications for operation, methods of surgical management and the results of operative therapy.

THE NATURAL HISTORY of most congenital cardiac lesions is now well documented and it is evident that operation is mandatory during infancy in many instances both as a lifesaving measure as well as to accommodate satisfactory growth and development. The surgical armamentarium has broadened steadily and the benefits of operative intervention have been extended to an extensively younger age group. Although these procedures are frequently palliative in nature, they allow the stricken child to attain a critical size at which cardiopulmonary bypass can be used safely for complete operative repairs. One hundred and twelve children below 2 years of age have been operated on for congenital heart disease at the University Hospital. Eighty-six were less than 12 months old and 70 per cent of these less than six months. This report is concerned with a description of the cardiac lesions, the indications for operation, methods of surgical management, and the results of operative therapy.

In our experience, patent ductus arteriosus is the most common cardiac anomaly for which operative repair is performed in the age group below 2 years. While frequently present as an isolated defect, it is also commonly associated with other lesions such as ventricular septal defect and coarctation of the aorta. We recommend operation for all children above 18 months with no contraindications to thoracotomy. Below that age level, congestive heart failure and recurrent pulmonary infections resulting from heavy pulmonary recirculation are the usual indications for surgery. Since the gravity of symptoms often does not correlate with the diameter of the ductus in children less than three months, the rate of decline of pulmonary vascular resistance must be the critical determinant in the genesis of a left to right shunt of life-threatening magnitude.

The ductus is exposed through a left posterolateral thoracotomy in the fourth interspace and is cautiously mobilized while great care is taken to avoid injury to adjacent structures, i.e., the left vagus and recurrent laryngeal nerves and the thoracic duct (Figure 1). Division of the ductus is preferred to avoid the remote possibility of recanalization, although an expeditious, double ligation without division is used occasionally in the

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critically ill neonate or infant less than six pounds. When pulmonary hypertension is present, the pulmonary arterial pressure must be measured during preliminary, temporary occlusion of the ductus. In most instances, a further rise in pressure indicates that it cannot be closed without producing right ventricular failure.

CASE SERIES

Twenty-nine infants with an average age of 12 months have been operated on for isolated patent ductus arteriosus. Of these, 25 per cent were less than three months. The pulmonary artery pressure fell or remained at normal levels in all instances and survival was 100 per cent. Six infants with an associated ventricular septal defect were also treated by simple ablation of the ductus. Five survived and exhibited prompt resolution of cardiac failure.

A particularly lethal, complex anomaly for which nine patients underwent urgent thoracotomy consisted of patent ductus arteriosus and coarctation of the aorta with or without a ventricular septal defect. All were refractory to medical therapy and were in terminal congestive heart failure. Operation was carried out as a last resort and consisted of ablation of the ductus arteriosus alone when the length of the coarcted segment precluded resection and end-to-end anastomosis. In the remainder, the coarctation was repaired, the ductus divided, and on occasion, the main pulmonary artery banded. One-third of these critically ill infants recovered from operation.

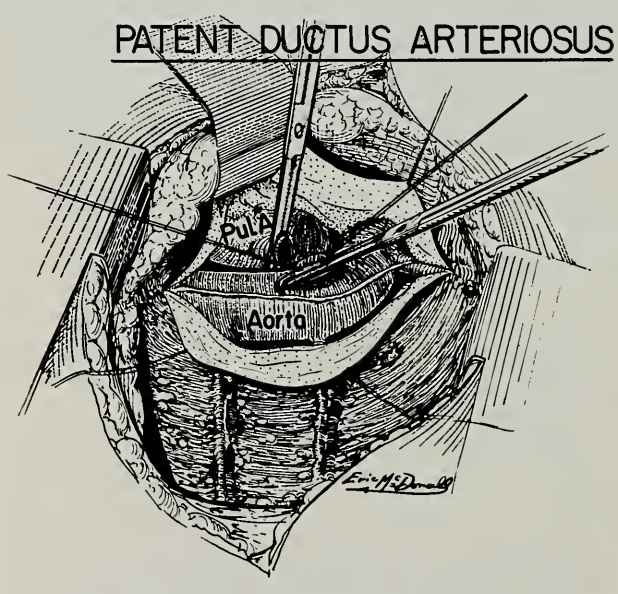


Figure 1. In most instances, the ductus is divided between clamps and oversewn to avoid the remote possibility of recanalization.

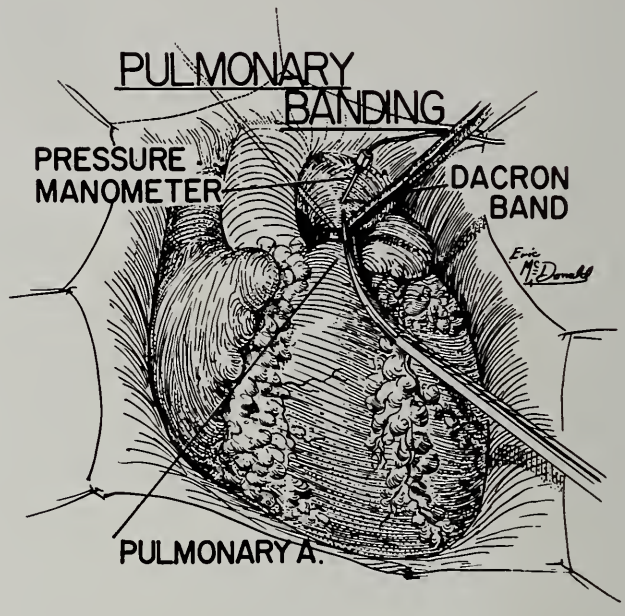


Figure 2. The main pulmonary artery is constricted with a dacron band during continuous monitoring of the distal pulmonary arterial pressure. A 75 per cent reduction in diameter with maintenance of satisfactory myocardial oxygenation is the desired end point for this procedure.

While the overall incidence of hemodynamically significant ventricular septal defect appears to be declining steadily in the older child, it continues to be the cardiac anomaly most commonly requiring pulmonary artery banding in the child less than 2 years of age. Intractable congestive heart failure due to increased left ventricular flow work coupled with heavy pulmonary recirculation constitutes the major indication for operation in this group of patients. The pulmonary arterial blood pressure is frequently at systemic levels in these infants and is invariably hyperkinetic in character.

TECHNIQUE EMPLOYED

A median sternotomy approach without violation of the pleural spaces affords excellent exposure of the pulmonary artery with minimal manipulation of the heart and, in our opinion, less postoperative pulmonary dysfunction. A dacron band is placed about the artery just above the valve and gradually tightened until the diameter

of the vessel is reduced to one-third its original size (Figure 2). With this degree of narrowing, there is usually some decline in the distal pulmonary artery pressure. However, pressure decreases greater than 50 per cent are poorly tolerated and are avoided. If myocardial cyanosis appears before the intended level of constriction is reached, the band is loosened just enough to allow full myocardial oxygenation and is fixed at this point. The band is anchored to the adventitia of the vessel with a few sutures to prevent its migration to the pulmonary artery bifurcation.

BANDING OF ARTERY

Pulmonary artery banding was performed for isolated ventricular septal defects in 11 infants, eight of whom were less than four months of age. In all instances, systemic arterial pressure increased substantially and sometimes doubled due to the more equitable distribution of total cardiac output. Survival in this group was 82 per cent. The procedure was also commonly used for other anomalies with high pulmonary flow states, notably transposition of the great vessels, which is described below.

While isolated pulmonic valve stenosis is not commonly met in the child below two years of age, the clinical manifestations are usually dramatic. Heart failure and cyanosis are often present and are attended by marked anxiety and breathlessness. Some of our patients were actually in a moribund state when admitted for emergency operation. Pulmonary valve gradients usually exceed 100 mm. Hg and right to left shunting through a patent foramen ovale can be demonstrated by right heart cineangiography.

The median sternotomy approach offers equally adequate exposure for either the transventricular or transarterial approach to the valve. In the absence of obvious technical advantages of one method over the other, the transarterial valvulotomy is preferred with inflow occlusion and moderate hypothermia to accommodate more accurate division of the valve commissures (Figure 3). When the Brock method of valvulotomy is used, we have noted that inflow occlusion protects the right ventricle from acute distention and may prevent a fatal arrhythmia.

Isolated pulmonic valve stenosis was successfully relieved in five infants with a reduction in the valve gradient below 40 mm. Hg. In all instances, the response to operation was characterized by prompt resolution of congestive failure and immediate improvement in peripheral oxygen saturation.

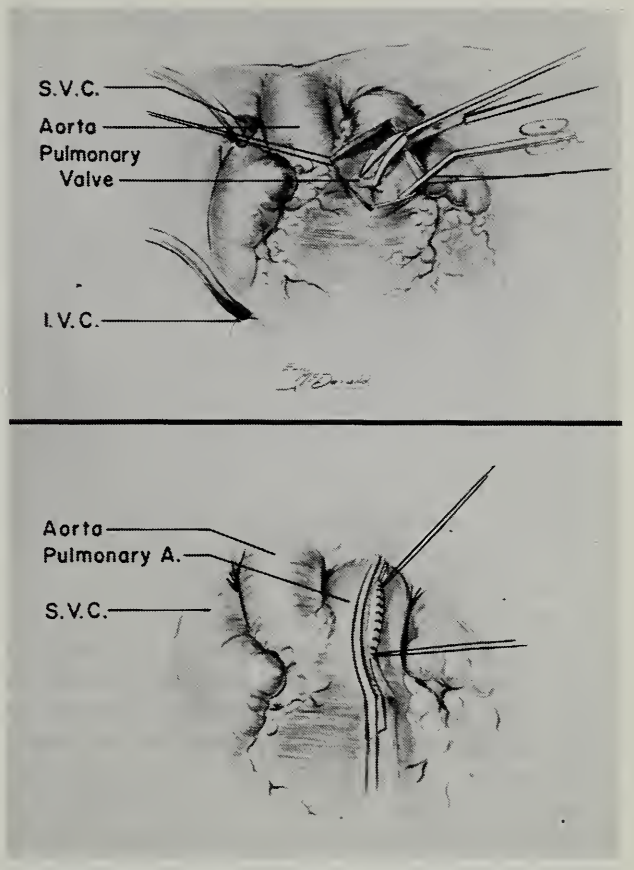


Figure 3. (a) During caval occlusion, the main pulmonary artery is incised just above the pulmonary valve. (b) Following valvulotomy, the pulmonary arteriotomy is closed with an atraumatic clamp to allow immediate restoration of circulation.

Transposition of the great vessels in its various forms constitutes the second most common congenital cardiac lesion treated during infancy. With few exceptions, the presence of refractory congestive heart failure and/or progressive cyanosis demands surgical intervention in infants below the age of six months. The time of onset and severity of symptoms is determined largely by the presence or absence of associated lesions. In our experience, those patients with a large atrial and ventricular septal defect plus pulmonary stenosis survive longest because of optimal mixing on one hand and a check on pulmonary circulatory overload on the other. Conversely, infants with only a patent foramen ovale or small atrial septal defect are critically ill within the first few days of life and present a significant therapeutic challenge, particularly since they are the best candidates for total correction at a later date.

Balloon septotomy by the technique of Raskkin provides a reasonable compromise to thoracotomy in the neonate whose primary hemodynamic deficit is inadequate mixing. Here a balloon-tipped

catheter is passed from a peripheral vein into the left atrium through a patent foramen ovale or small atrial septal defect. When the inflated balloon is rapidly drawn back into the right atrium, the septum is ripped, thereby enlarging the inter-atrial communication. Although the procedure may be life-saving, a subsequent atrial septectomy is often necessary.

BLALOCK-HANLON METHOD

We have used the ingenious method of Blalock and Hanlon for excision of the atrial septum. This procedure is best performed through a right anterolateral incision in the fourth interspace during temporary occlusion of the pulmonary arterial and venous circulation on the right side. The inter-atrial septum is isolated between parallel right and left atrial incisions during exclusion of the atrial walls at the entry of the right pulmonary veins, delivered between the jaws of the atraumatic clamp and excised (Figure 4). A major disadvantage of the procedure consists of the menacing decrease in cardiac rate sometimes to the point of arrest during the cessation of pulmonary circulation on the right side. Some tolerance appears to be offered by hyperventilation and the administration of atropine and sodium bicarbonate just prior to the period of pulmonary occlusion.

In some instances, pulmonary artery banding is performed simultaneously with atrial septectomy to promote a more equitable distribution of cardiac output. However, the procedure is usually reserved for infants in congestive heart failure due to excessive pulmonary blood flow resulting from a large left to right shunt at the atrial and/or ventricular levels. Banding of the pulmonary artery has a benevolent effect here for at least three reasons. First, it increases the systemic cardiac output with an immediate rise of arterial pressure and improved tissue perfusion. Second, it improves peripheral arterial oxygen saturation by increasing the shunt of fully saturated pulmonary venous return into the systemic ventricle. Third, it immediately relieves pulmonary congestion and the adverse effect on gas exchange, and at the same time, protects the lungs from the irreversible vascular changes accompanying chronically excessive pulmonary blood flow.

BANDING RATIONALE

Since irreversible pulmonary hypertension commonly prohibits the possibility of subsequent correction by one of the techniques of venous trans-

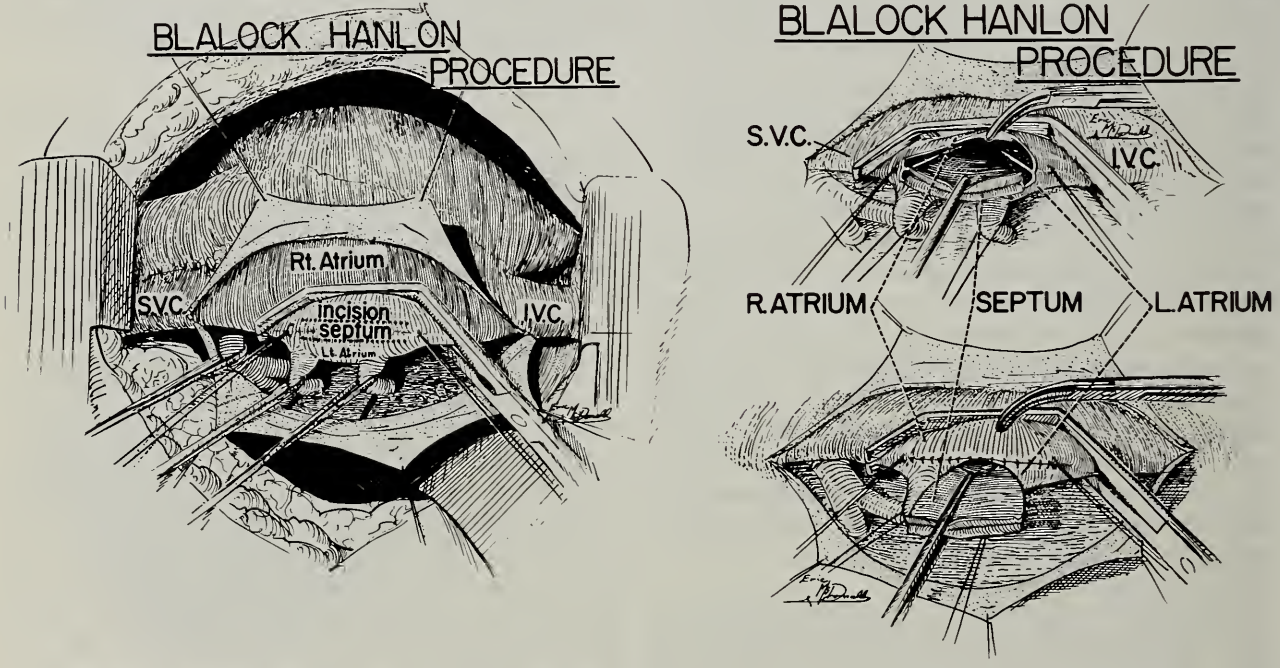


Figure 4. (a) A segment of the left atrium adjacent to the right pulmonary veins, the over-lying right atrium, and the intervening septum are isolated with a vascular clamp. (b) Through parallel incisions in the right and left atria respectively, the septum is exposed, grasped with forceps and excised. (c) The cut edge of the septum is allowed to retract inward and the edges of the right and left atria are approximated with a continuous suture.

position, there may be some rationale for pulmonary artery banding in infants with a pulmonary artery pressure at systemic levels in the absence of heart failure.

Twenty-two infants underwent palliative surgery for transposition of the great vessels. There were no other anomalies excluding a patent foramen ovale in six patients. The remainder had the following associated lesions: ventricular septal defect in six, ventricular septal defect plus patent ductus arteriosus in two, ventricular septal defect plus mitral atresia in two, ventricular septal defect plus tricuspid atresia in five, and pulmonary stenosis in one. Cyanosis and hypoxemia were the primary indications for surgery in 12 patients; whereas, unresponsive congestive heart failure was the major complaint in the remainder. An atrial septectomy was performed in 11 patients with seven survivors and pulmonary artery banding in seven others with four survivors. The procedures were combined successfully in two patients. A Blalock-Taussig procedure was selected for palliation in two instances. The overall survival rate was 64 per cent.

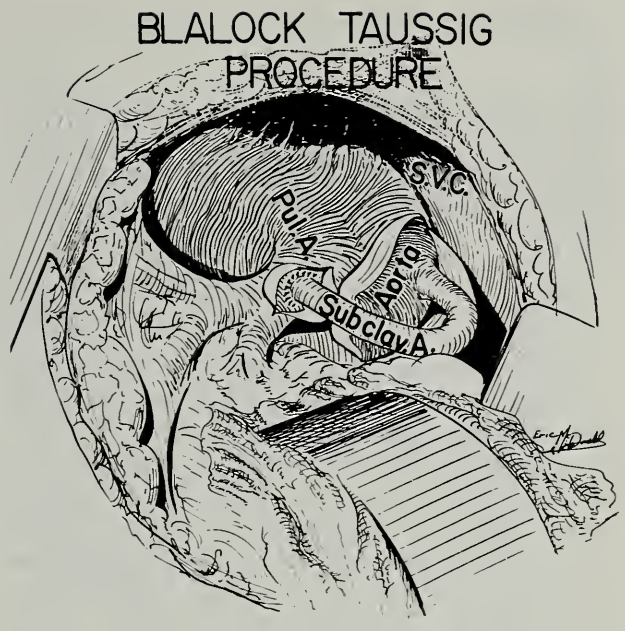


Figure 5. The subclavian artery is mobilized to its exit from the thoracic cavity and all branches divided and ligated. This almost invariably affords adequate length for the creation of a satisfactory systemic-pulmonary artery shunt.

RANGE OF ANOMALIES

A spectrum of cardiac anomalies is now commonly included under the term Tetralogy of Fallot ranging from pulmonary stenosis plus a ventricular septal defect to complete pulmonary atresia and origin of pulmonary blood flow from the aorta, the so-called pseudotruncus. Below the age of two, we are concerned only with those lesions which produce severe and progressive cyanosis resulting in hypoxic episodes, growth retardation, and a pronounced susceptibility to respiratory infections. Approximately one-half of our patients were less than six months old and were threatened with critically severe hypoxemia. In all instances, a pulmonary-systemic shunt was used to increase peripheral oxygen saturation.

For the most part, we have preferred the Blalock-Taussig anastomosis on the left side (the side of the aortic arch) because of the greater length of the subclavian artery (Figure 5). On one occasion in which the subclavian artery on the side opposite the aortic arch was used, a fatal occlusion developed at the bifurcation of the innominate artery. Great care is taken to preserve the ansa subclavii which loops about the subclavian artery carrying sympathetic fibers from the cervical ganglion. Inadvertent or deliberate injury of this small nerve during mobilization of the vessel may produce a Horner's syndrome.

The vertebral artery is always ligated to provide a longer subclavian artery as well as to avoid the possibility of a subclavian steal syndrome on that side as the child matures. At least half of the anastomosis is constructed with interrupted sutures to permit enlargement during subsequent growth. The usual left-sided approach has allowed side to side anastomosis of the aorta and left pulmonary artery when the left subclavian artery was unsatisfactory for a reliable shunt.

We have not used the ascending aorta-right pulmonary artery shunt clinically, although it may provide a satisfactory method of operative management for the infant less than 10 pounds. Although the procedure is technically cumbersome in the experimental animal, the shunt can be more easily closed than the Potts anastomosis when the anomaly is totally corrected.

SHUNT CONSTRUCTION CAUTION

Caution must be exercised during the construction of aorto-pulmonary shunts to avoid too large an anastomosis which may produce fatal congestive heart failure. For this reason, we prefer the subclavian-pulmonary artery anastomosis since the diameter of the subclavian artery constitutes a natural check on the magnitude of the shunt.

Pulmonary-systemic shunts have been created in 16 infants with Tetralogy of Fallot. The Bla-

lock-Taussig procedure was used in 14 and the Potts procedure in 2. Eighty-one per cent survived operation, were relieved of hypoxic episodes, and exhibited a gratifying response in growth and development.

ANOMALIES RARELY ENCOUNTERED

Other cardiac anomalies which were rarely encountered in this age group included tricuspid atresia, truncus arteriosus, total anomalous pulmonary venous drainage, corrected transposition, and double aortic arch. One-half of these patients were in the neonatal period and most were both severely hypoxemic and in terminal congestive heart failure. A variety of palliative procedures were used with survival in one-third.

The steady improvement in operative management of these fragile patients is in no small measure due to the conduct of anesthetic management during which attention is directed to maintaining a satisfactory body temperature, optimal oxygenation, normal acid-base balance, an acceptable cardiac rate, and accurate blood replacement (Figure 6). In many instances, the period of anesthesia provides the safest harbor for the infant from the time of hospital admission to the recovery of some vigor postoperatively.

In the postoperative period, the major threat to survival resides in the pronounced tendency for early postoperative pulmonary complications to develop, particularly in the cyanotic group and usually with alarming speed. Pulmonary secretions are always increased and bronchial obstruction is commonly met. Both tracheostomy and an indwelling endotracheal airway have been alternately used to provide a route for assisted ventilation as well as for facile tracheobronchial suction aspiration. However, neither adjunct should be applied in a cavalier manner since they may lead to catastrophic complications.

In general, we have relied upon a maximally humidified environment to prevent drying and inspissation of secretions, supplemental oxygen to provide optimal gas exchange, and frequent naso-

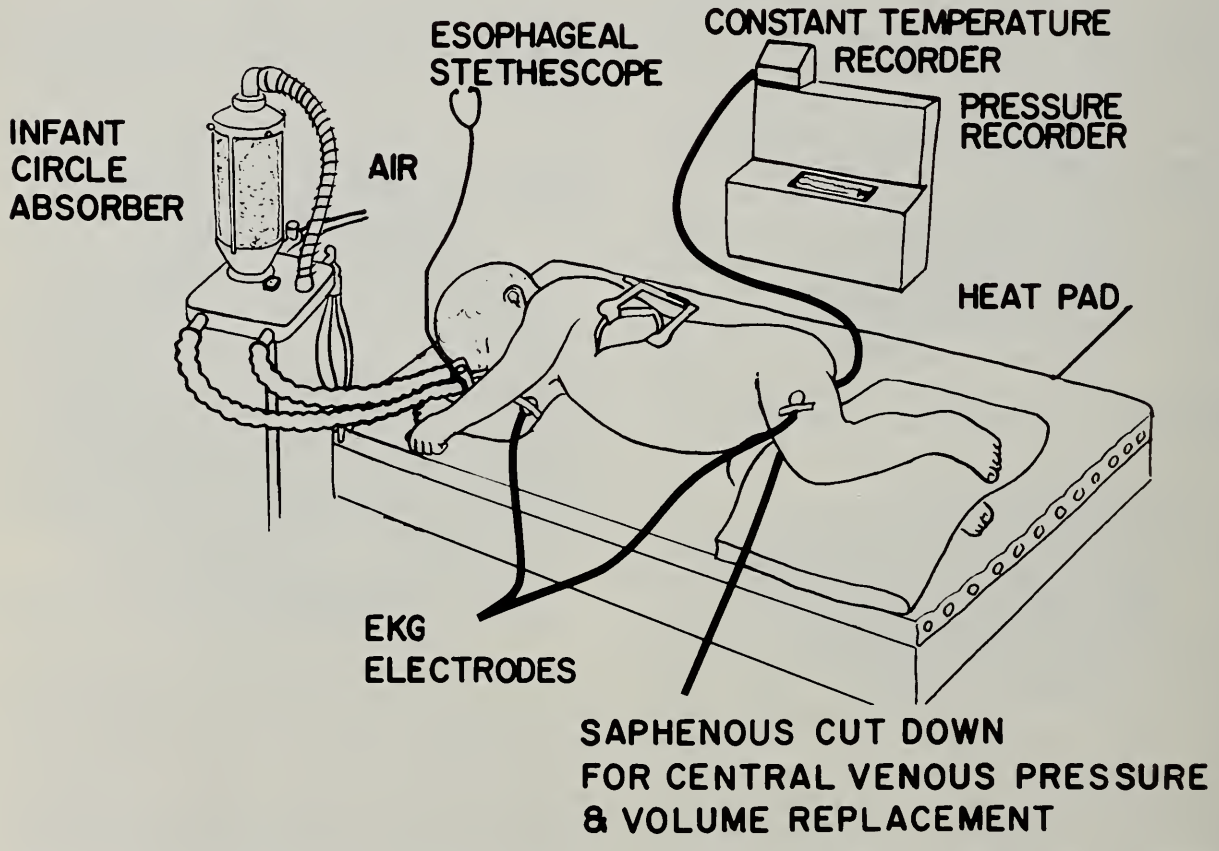


Figure 6. The adjuncts used for continuous observation of vital functions during infant cardiac surgery are illustrated diagramatically. Acidosis is avoided by adequate oxygenation, removal of CO_2 and the maintenance of an optimal blood volume and body temperature.

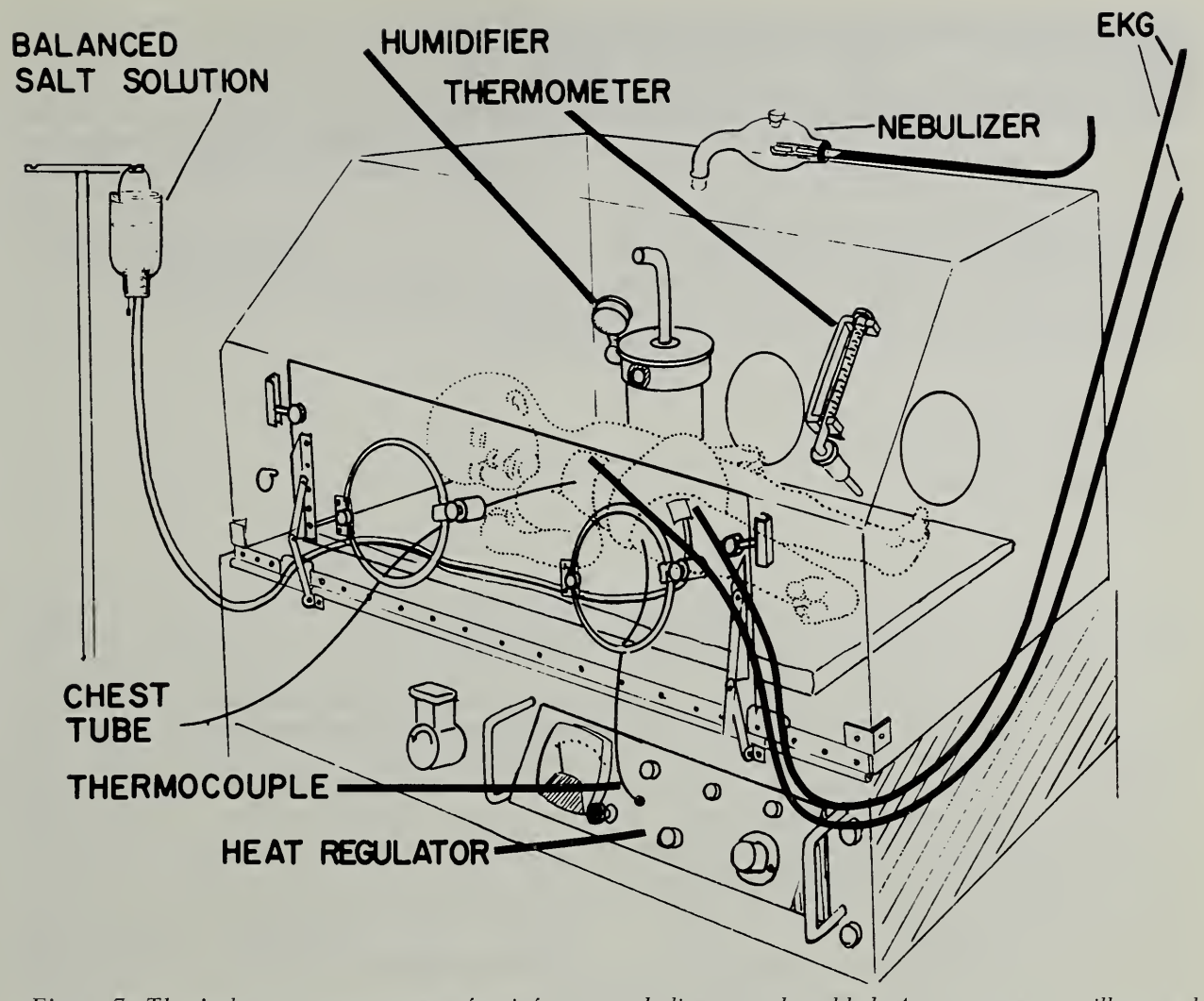


Figure 7. The isolette support system for infants illustrated here includes portals for oxygen lines, EKG leads, chest tubes, intravenous lines and, if necessary, the tubing of a mechanical ventilator. A nebulizer may be added. An apparatus not illustrated here will monitor respiratory rate and trigger an alarm if apnea occurs.

pharyngeal stimulation to promote effective coughing (Figure 7). A nasogastric tube is inserted in the immediate postoperative period and the stomach is kept empty until feedings are started to avoid aspiration of gastric contents. Corticoids are routinely used within the first 24 to 48 hours to suppress laryngeal and tracheobronchial edema.

TEMPERATURE CONTROL

Since the infant is particularly prone to hypothermia with its adverse effects on cardiac performance and peripheral perfusion, a servo-regulatory device is used to control the ambient temperature according to the skin temperature. Small increments of sodium bicarbonate (⅙ molar solution—5 cc.) are used as indicated to maintain a normal pH. Fluids are restricted to 50 cc. per kg. when congestive heart failure has been present and both sodium and potassium are added to cover the usual urinary loss of these cations.

Oral feedings are not resumed until the infant can be burped. Tube feedings can be given as a suitable compromise; however, the feeding tube must be irrigated and aspirated at frequent intervals to avoid gastric distention.

Most complications can be avoided or reversed at an early stage by frequent firsthand supervision by the attending staff and continuous observation by a competent nursing staff which is specially trained in the postoperative management of these patients. Finally, an expediously performed, technically perfect operative procedure remains the hallmark of a relatively smooth postoperative period and a successful outcome.

SUMMARY

One hundred and twelve children less than two years of age underwent palliative or corrective cardiac surgery at the University Hospital. Sixty-one were treated for acyanotic cardiac lesions with an operative survival of 85 per cent and no late death. Palliative procedures were performed in 51 infants with cyanotic heart disease. Survival here was 75 per cent with a late mortality of 8 per cent. A successful result was largely dependent upon correct diagnosis, an expeditious operative procedure and meticulous cardiopulmonary support during and incident to operation.

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SLIGHT INFLATION

An astronaut volunteered for a space mission which required his being in orbit for 10 years. Just before blastoff, he telephoned his broker and instructed him to invest $1,000 in stocks.

The mission was successful, and the astronaut splashed down off the coast of Florida after 10 years in orbit. Arriving at Cape Kennedy, he immediately telephoned his broker in New York and asked how his investment had done.

"Great," replied the broker. "Your investment is now worth $3 million!"

"Wonderful," replied the elated astronaut. "Now I can have a new home, cars, a plane, and a yacht."

At that moment, the long distance operator interrupted: "Your three minutes are up. Please deposit one million dollars."

Day of Decision: Medicaid for Mississippi?

ROWLAND B. KENNEDY
Jackson, Mississippi

MISSISSIPPI MUST make an 11th hour decision on Medicaid, Title XIX of the Social Security Act, and the clock is ticking off the last minutes of the crucial hour. On the law's fourth birthday, Jan. 1, 1970, states which have not adopted the federal partnership program for care of the indigent and needy may receive no more funds for welfare health services.

Governor Williams has called the Legislature into special session to make the go-no-go decision, and despite the cold fact that his is the most health-conscious administration since Governor Hugh White's in the 1930's, the timing couldn't be worse:

—Item: *The state is sitting on the deadline for the clock to run out on federal funds for care of the indigent and needy.*

Medicaid became effective Jan. 1, 1966, and 39 states and the District of Columbia have already adopted programs. With the mounting costs of state government and programs, it was easy enough for Mississippi to defer judgment. Now, the Legislature must work under the pressure of a doomsday deadline. If a program is enacted, a new state agency must be organized and an acceptable plan devised. In a nutshell, it's the last of the ninth with two away.

—Item: *Medicaid isn't a nice word in some quarters, because it has become synonymous with the slick boondoggle and the fast buck.*

In the whole context of the program, Medicaid has a good record. But the open end eligibility goof in New York, uncontrolled utilization in Kentucky, bankruptcy in New Mexico, and allegations of boondoggling in California tarnish the gilt and leave an unpleasant aftertaste.

At a time when Medicaid is identified with boondoggles and windfalls, the Legislature has been called into special session to consider a program for Mississippi. The state medical association, firmly established with a clearly defined policy on Medicaid, stands ready to state its position with candor on the circumstances under which it feels that the needy patient, the state, providers, and taxpayers will fare best in caring for those who need help.

The present hodgepodge of disembodied care programs poses the challenge which must be met under a doomsday deadline. The day of decision for Mississippi is now.

The most conservative Congress since Truman's famous 80th is getting toxic doses of virulent opposition, regrettably based upon examples and isolated incidents—not on overall program performance and the general stewardship of the states. This is injurious to that vast and overwhelming majority of physicians, hospitals, and allied professions who have acquitted themselves honorably and effectively in caring for beneficiaries.

—Item: *In a humane effort of enlightened self-interest, man has never before managed to write a more horrendously complex law than Medicaid. Few individuals really understand it.*

Executive Secretary, Mississippi State Medical Association.

What we do not understand, we tend to fear or dislike. The roots of Medicaid go back to the original welfare titles of the Social Security Act of 1935, and the 1965 enactment is a direct evolutionary process dating from 1950. There are literally thousands of pages of law, regulations, guides, and policies relating to Medicaid.

Early in his administration, Governor Williams demonstrated that he understood this problem, and he pressed for passage of Senate Concurrent Resolution 129 in the Legislature under which he appointed a 23-member, blue-ribbon Public Health Advisory Committee to study and plan for Medicaid. The Legislature responded with alacrity, showing the same understanding.

During 1967-68, the state medical association sponsored a series of nine regional meetings on Title XIX Medicaid. Arranged through component medical societies, the meetings were information sessions for physicians, hospital personnel, legislators, and community leaders.

Tons of pamphlets, brochures, articles, tracts, and flyers on Medicaid have flooded the medical profession and lawmakers. But it follows that just as one cannot become a physician through a correspondence and sporadic lecture course, neither can one become expert in advanced medical socioeconomics and publicly financed delivery systems through the same mode of instruction.

MORE PURCHASING POWER

—Item: *The prospect of expanding the medical care purchasing base to the indigent and near-needy under a squeeze-cost formula can't be too encouraging to health care providers who are already in short supply.*

Nixon administration spokesmen are dropping ominous warnings of cutting professional fees under Medicaid back to prevailing Blue Shield benefits in the several states. The White House has sliced the $3.1 billion Medicaid budget by 17 per cent.

Hospitals are protesting reimbursement rates as their costs continue to zoom. And the states, for want of federal matching funds, may have to reduce local programs by a national aggregate of $1 billion in fiscal 1970.

It is against this background that the special session of the Mississippi Legislature receives the recommendations of the Public Health Advisory Committee for a Medicaid program. And while there is real and significant opposition to any expansion of welfare benefits among some good and sincere Mississippians, the opportunity is ripe and golden to assure that every citizen who needs medical care receives it.

The Mississippi State Medical Association supports Title XIX Medicaid under a six-point positive program related to local controls; free choice of physician, hospital, and nursing home; reappraisal of existing fragmented, overlapping, inequitable token programs of care for the indigent; medically oriented fiscal administration; and discontinuance of any present program which could be incorporated into Title XIX.

NO OPEN END PLANS

But it is unlikely that the association will endorse bargain basement medical care or a sky-blue, open end bonanza. It has historically been the posture of Mississippi physicians that help should be given those with demonstrable need, and the principles of Title XIX meet this criterion.

In 1967, the House of Delegates reviewed 10 years of policy and defined with painstaking care a position of support for Medicaid. A *definition policy* applying to "statutorily established and medically accepted programs of government which are not disapproved by the association" found Title XIX simon pure.

Medicaid met the test under an *acceptability policy* which had been drawn back in the Forand and King-Anderson days. The association opposes federal programs which incorporate universal compulsion, total federal funding, no local controls, and benefit eligibility without reference to need, resources, or means. As was the case with Kerr-Mills, none of these proscriptions applies to Medicaid.

Another crucial tenet is the progression of responsibility for care under the association's *criteria policy*. It all begins with the individual, moving up through the family, community, county, and state. The federal government enters the picture only when the resources of all of these are fully utilized or fail.

FREE CHOICE, LOCAL CONTROL

Then, continues the policy, "the determination of medical need should be made by a physician, and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care is inherent in this concept."

Medicaid meets these tests.

It was in 1962 that the House of Delegates advanced its *adequacy policy,* stating that "there has been an insufficient implementation of the Kerr-Mills program in Mississippi. This implementation is less than that necessary or satisfactory as regards physicians, hospitals, and the public." Clearly, the goal was more and better means for caring for the indigent.

Finally, a *responsibility policy,* relating to the association's legitimate interests in Title XIX, pointed out that physicians also had an obligation and duty in this connection.

Within these broad but well-defined perimeters, the Mississippi State Medical Association continues to support Medicaid, keeping foremost a sense of realism about the character and content of the program, how it is operated, and who benefits from it. Mississippi physicians want to help those who need help. They believe in a means test, and they want no part of boondoggles and windfalls.

PART OF MEDICARE

To be hair-splittingly technical about it, Medicaid is Title XIX of the Social Security Act, Public Law 89-97, 89th Congress, enacted July 30, 1965, and codified as 79 U. S. Statute 286. With that legal mouthful aside, it was substantially amended in 1967 by Public Law 90-248, actually enacted on Jan. 2, 1968.

Medicaid rode into the law books on the coattails of Medicare which is Title XVIII. Briefly, it is a three-layer cake to be implemented only at the option of a state after affirmative action by its legislature.

In a sense, it is a carrot and a stick. The carrot is generous federal matching funds for services which the state feels it needs for its indigent sick. The stick is no more federal funds if the state elects to go it alone. That's what the Jan. 1, 1970, deadline is all about.

When a state enacts Medicaid, it must include as beneficiaries all who receive cash grants, as welfare checks are called, and all children under age 21 who would be eligible for Aid to Families with Dependent Children (AFDC). This means the old age, blind, AFDC group, and the permanently and totally disabled who receive welfare payments.

The second layer includes those who, if sufficiently needy, would qualify for such welfare benefits. This is to say a blind person whose income is barely sufficient for food, shelter, and clothing but who does not receive welfare benefits. If sufficiently needy, such as in time of great medical need, he could qualify and thus, be eligible for Medicaid. This category is sometimes called the near-needy.

The third group are those between ages 21 and 64 who would not qualify under the four welfare titles but who, at one time or another, may need help in purchasing part or all of their medical care. This also is the controversial group, because the state must finance the entire package without federal help.

ONWARD AND UPWARD

Here is where the now-celebrated Section 1903(e) enters the picture. It is the "onward and upward" clause in the law with the 1975 deadline requiring all states with Medicaid to furnish "comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources. . . ." Because virtually no state, large or small, rich or poor, can meet this pie-in-the-sky goal, Section 1903(e) is about to go out the Congressional window without regret.

There is bipartisan support for its repeal, thereby permitting the program to regress where necessary to realistic levels of service and eligibility within the means of the states and federal government to pay the bill. The Senate has agreed to pass the repeal measure on a voice vote as a rider to a noncontroversial House bill without committee hearings. This would send the measure to conference between the House and Senate without recorded opposition, assuring clear sailing.

So the states will be off the hook for the treasury-draining comprehensive care for everybody. Once the errors of haste and maladministration of some few programs have been cleaned up, Title XIX will work for the American people as it should. This is what the Mississippi State Medical Association supports.

STATES MAY CHOOSE

Under the original enactment, a state may offer just about any health service it wishes under Medicaid. This breadth of choice reserved to the states has been the downfall of a few. The program does require a basic five-service plan including inpatient care, outpatient care, laboratory and x-ray services, nursing home care for those over 21, and the services of physicians in the office, home, nursing home, hospital, or elsewhere.

More recent amendments added periodic screening and diagnostic services for beneficiaries under age 21 and home health services (made popular under Medicare) for those eligible for nursing home services.

The proposed Mississippi program lists 11 services, the seven outlined plus ambulance transportation ordered by a physician, prescribed legend drugs and insulin, emergency dental extractions and treatment related thereto, and eyeglasses following eye surgery.

All of this, the Public Health Advisory Committee believes, can be furnished for $41 million a year with the state putting up about $8 million under the most generous of all matching formulae, 83 per cent federal share against which is matched the state's 17 per cent.

The tentative budget for which the Legislature is fully expected to make a line-item appropriation includes about $6.8 million for inpatient hospital services, $537,000 for outpatient care, and $8.3 million for physicians' services.

Blood and anesthesia are estimated at $1.2 million, and $1 million is set up for laboratory services. Other items are $300,000 for x-ray work, $9 million for nursing home care, $800,000 for screening and diagnostic services, just under $100,000 for home health services, and $50,000 for ambulance transportation.

PRESCRIPTION DRUGS

The prescription drug program is optimistically pegged for $5.5 million, about $250,000 is estimated for emergency dental extractions, and $50,000 is included for eyeglasses following eye surgery.

The buy-in for over-65 beneficiaries in Part 1-B of Medicare, the $4 per month premium, comes to $3.4 million. Under the 1967 amendments, the federal government will no longer pay for any service under Medicaid which could have been provided under Medicare. Moreover, the federal share will not be used for buying-in Part 1-B, the rationale being that the federal government is already paying half with the other $4.

The committee's estimates say it will cost $3.7 million to administer the program, and the proposal would permit contracting with a "health insurance company" for underwriting or for serving as a fiscal administrator. An underwritten program could be deadly, because in the final analysis, the state must pay the entire bill including losses, administration, and actuarial costs. The fiscal administrator concept is down the line at-cost with nobody assuming an actuarial risk. Medicare and CHAMPUS are solid proof of the wisdom of at-cost administration.

Medicaid will be run by a newly created interagency commission. No provision is made for representation on the commission by the medical profession, hospital, nursing homes, pharmacy, or any of the allied professions. Some members of the Public Health Advisory Committee contend that to have such representation would constitute a conflict of interests. The commission chairman must be among the public members.

COMMISSION'S POWERS

The Medicaid Commission would be given broad and flexible powers. It may make reasonable rules and regulations, conclude contracts with other state agencies and insurance companies, and even juggle the money around to pay the bills. Implicit in this power is authority to reduce either the scope of services in time of financial squeeze or payments to providers or both.

Since terms of public members are for five years on a staggered basis and since the appointive powers of the governor are limited among most of the state agencies represented, it is reasonable to believe that the commission could not, in future years, be stacked.

The commission will have a director and staff, and the federal statute also requires a medical unit, including a physician-chief. Provision is made for a medical advisory committee, where, presumably, care providers will have a voice—but obviously one which is subservient to the will of the commission.

As proposed, Medicaid in Mississippi will offer health services to about 202,000 citizens. These include 71,000 Old Age Assistance recipients under Title I; 86,000 under Aid to Families with Dependent Children, Title IV; 2,300 beneficiaries under Aid to the Blind, Title X; and 23,000 under Title XIV, Aid to the Permanently and Totally Disabled. Rounding out the list are an estimated 20,000 children between the ages of 16 and 21 who are in AFDC families.

NEAR-NEEDY

In its recently published study of Information Systems for Comprehensive Health Planning, the state medical association estimated that there are about 400,000 citizens who might qualify in the near-needy classification. Under the present proposal, this is another problem for another day. It cannot, however, go unnoticed that there are

253,000 households in Mississippi with combined annual incomes under $3,000, and this is a third of the population.

In the administration of Medicaid, Title VI of the Civil Rights Act of 1964 will rigorously apply. The Medicaid Commission will be responsible for enforcement of the title and for assuring compliance by all providers. Under the strict letter of the law, Title VI does not prohibit a physician from discriminating. Rather, it provides that he cannot be paid for his services under a federally assisted program if he does discriminate.

No physician is required legally to accept welfare patients eligible for benefits under federally assisted programs. If he does accept such patients, he is not required to accept payment for his services. If he does accept payment, then he may not discriminate among welfare patients on the basis of race, color, or national origin.

The Mississippi Medicaid program must also provide against disclosure or use of information about applicants and recipients except for purposes directly connected with program administration. The state may not make available for general inspection any record on medical care and medical care costs for individual Medicaid beneficiaries.

If the pitfalls are substantial, then the challenge is even greater. Mississippi is a textbook example of almost totally uncoordinated health care programs for the needy, a hodgepodge of disembodied statutory entities which duplicate, overlap, and impose inequities upon patients, providers, and taxpayers. A partial listing drives home the point:

—The charity hospitals, four institutions which could not now possibly qualify for accreditation, none of which is north of Highway 80 (Interstate 20).

—The State Hospital Commission program, providing only partial and inadequate reimbursement to hospitals and nothing for medical and related services.

—A host of health care and rehabilitation programs under the State Department of Education.

—Insufficient—even token—vendor care programs under three of the four welfare titles.

—A dozen or more inadequately funded programs under the State Board of Health.

—Separate programs under the Board of Trustees of Mental Institutions, in the Cerebral Palsy Hospital School, the State Tuberculosis Sanatorium, and in various specialized facilities.

There has been inertia in Mississippi in coming to grips with the need to reappraise, readjust, and to make changes long overdue. There has been evolution rather than origination, and because this quagmire has been permitted to thicken and solidify, the state seems to have fallen into a pattern of reaction and belated response rather than progressing to one of timely preparation for meeting predictable needs.

The special session of the Legislature is a call to statesmanship, and the tasks will not be easy. Mississippi has the opportunity to move a generation ahead in locally controlled health care for the needy. The mistakes, errors of judgment, and failures of others are potentially our profit. The day of decision is now. ★★★

735 Riverside Drive (39216)

UNDERCOVER MOTHER

"How are your children doing at school?" asked a friend.

"Better," replied the other, "but I still go to PTA under an assumed name."

—Mississippi Educational Advance

Radiologic Seminar LXXXV: Ascariasis Demonstrated by a G.I. Series

CLYDE SMITH, M.D.
Greenwood, Mississippi

ASCARIS LUMBRICOIDES is the most widely distributed parasitic worm in man. They occur more frequently in children than in adults. The worms vary from 15 to 40 cm in length and from 3 to 5 mm in width. While the diagnosis is most commonly made by a demonstration of the ova in the stools, the worms may also be demonstrated on barium studies. This technique was first described by Fritz in the German literature in 1922. It was first described in this country by Archer and Peterson in 1930.

The radiographic diagnosis is made by barium study of the small intestine. The worm is recognized as a filling defect in the barium-filled small intestine. They are usually in the jejunum. Barium sometimes clings to the surface of the worm itself which helps in making it visible. The characteristic size and shape of the worm makes it an unmistakable finding on the barium studies. Usually, they are parallel with the lumen of the small bowel. They may lie in any direction. Sometimes the worm will ingest the barium, at which time the G.I. tract of the worm itself is visible.

The case illustrated is of a nine-year-old Negro male admitted to the Greenwood LeFlore Hospital with a history of peri-umbilical pain for three days with vomiting for one day. Physical examination revealed slight generalized abdominal tenderness. W.B.C. was negative, with three eosinophils. Stools were negative for parasites or ova.



Figure 1. Filling defect within lumen of jejunum due to ascaris worm as demonstrated on upper G.I. series.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Greenwood LeFlore Hospital.

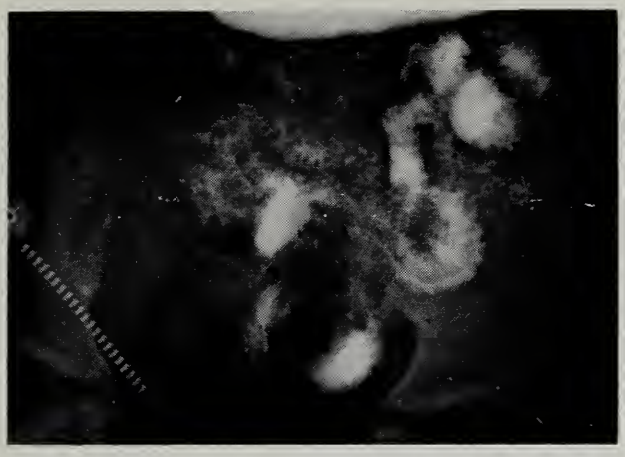


Figure 2. Enlargement of infested area in jejunum.

Because of the G.I. complaints, an upper G.I. series was ordered. Fluoroscopy and films were negative except for the demonstration of the classic filling defects of ascaris within the jejunum. Administration of Antepar resulted in passage of many typical round worms from the rectum. ★★★

202 E. Market St. (38930)

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SOME ACT, MANN!

A marine biologist developed a theory that if dolphins were fed newly hatched sea gulls, they would live forever. He applied for and received a research grant to build a laboratory by the sea, affording him easy access to the dolphins and the source of food.

One day as he hauled a load of baby sea gulls to the laboratory, he was forced to stop his truck, because an old lion from the state zoological gardens was sleeping in the road. When the lion refused to move, the scientist drove over him.

Later, he was arrested. The charge: Transporting young gulls across a state lion for immortal purposes.

We Dare Not Do Less

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

I BELIEVE all of us dislike the fact that so much of our time and thought in medical meetings is devoted to socio-economic and political matters rather than to our chosen fields of medical science.

We live in a rapidly changing world that constantly challenges us, and medicine is in the forefront of these changes. Change, in itself, is not necessarily good. It is necessary to evaluate each change carefully and discard that which is unsound and adopt that which is good. In the healing arts, the medical profession, by training and experience, is best qualified to make these evaluations. Prodding by outside sources is desirable, but I believe that the profession can, will, and must do the job of guiding the course of medical care in America.

To do this we must look at the distant past to profit from mistakes that are history. We must look to the immediate past in an effort to correct errors before they have gone too far. We must take a hard look at the present to see that we realize our full potential. We must then use all this knowledge to plan intelligently for the future.

Some of the problems that face us today are: third parties in medicine, costs, manpower, delivery systems, and participation in the planning and execution of government programs. We are tempted to stick our heads in the sand and hope that these problems will go away. Indeed, many of our members do just that. But the dedicated people who have set about to change our whole society keep plugging away at the destruction of our free enterprise system, and the private practice of medicine is a prime target.

It was in the early '30s that the political forum took over with its controlled economy and began experimenting wtih supplying medical services. Voluntary pre-payment plans were born with the blessings of organized medicine. Thus, third party medicine arose and the physician fell into the trap: allowing government agencies, insurance companies, service plans, and even luncheon clubs to barter away his services.

The physician found himself enmeshed in forms and reports and all sorts of red tape. In order to find time to treat his patients, he stepped out of hospital management and brought in lay administrators, hired expensive insurance clerks, elaborate bookkeeping systems, tax experts, and on and on the costs pyramided.

For the first time, overhead expenses became a major factor in medical practice. The physician was no longer able to give his services without also incurring a heavy cash expense. He embraced government programs with reduced fees in order to help pay these costs and he watched these agencies spend more money for clerical help and case-workers than for patient care. At the same time they added to his overhead by demanding more mountains of paper work—a vicious cycle in rising costs.

It is time we reversed this cycle by dealing directly with our patients. This is well within the power of every physician. In several states this kind of program has been implemented by what is known as Individual Responsibility Programs. I recommend that you study this concept and discuss it with those who have tried it. You may modify the program in any way you desire. This is a purely voluntary program, one that re-instates the direct relationship of doctor and patient and frees the physician from the entanglements and misunderstandings of insurance contracts. It also places the insurance programs in proper perspective, since this is a contract made between the insuror and the insured in which the physician had no voice.

One of the major costs of every hospital, clinic, and doctor's office is that of processing and keep-

President, Mississippi State Medical Association, 1968-1969.

Read before the House of Delegates, 101st Annual Session, Biloxi, May 12-15, 1969.

ing books on insurance claims. This is a cost that should not be charged to medicine, but one that should properly be charged to the insurance industry. I once asked the medical director of one of the nation's largest insurors why they did not have people in their claims department who were more familiar with medical procedures. He stated that it would be too expensive. He was unmindful of the fact that they were taking the time of a highly trained physician and his staff to perform this function for his company at the physician's expense.

The purpose of these lengthy forms is to find a loophole for the insuror to get out of paying the claim. I have no criticism of these companies trying to protect their interests, but it should be done through their channels with the patient, by their agents, and at their expense. Let it be understood that we are not condemning the insuring of health hazards; we are simply suggesting a change in the physician's role.

The physician should not allow himself to be coerced into spending his time as arbiter for the insuror and insured, for in so doing he is apt to lose the good will of both. In short, we should quit spending our time as unpaid insurance adjusters and spend that time treating patients. This would help both the costs and manpower problems. This is a situation that needs correction and we should do it.

UTILIZATION PROBLEMS

We are all aware of the high cost of hospitalization. There are many procedures that can be done more quickly and economically in the office than in the hospital or emergency room. Over-utilization of hospitals in all its forms adds tremendously to medical costs, and we should work diligently to keep these costs down. Many other opportunities to reduce costs without reducing quality of care will occur to many of you. Let us put them into practice.

Much is being done to produce more trained manpower. It appears that this problem will eventually be solved, provided the incentives of private medical practice are not destroyed and, thus, the brightest minds diverted into other fields of endeavor. By incentives, I don't mean just money. The psychic reward of serving the sick—regardless of ability to pay—has drawn the highest type of people into medicine, as has the freedom to practice as one thinks best, to attract patients by excellence and superior performance rather than assignment by regional government agencies.

We need only look back to the times of Bismarck to see how medicine in Germany declined from world pre-eminence after socialized medicine was instituted. I spent enough time in Germany to fully appreciate the superiority of our system. Most of us are familiar with the outflow of medical talent from Great Britain and its replacement with inferior personnel from the colonies. To have quality medicine, we must be able to continue to attract quality personnel into medical practice.

DEMAND FOR SERVICES

The mounting demand for medical services has exerted strong pressures on our physician manpower. Most of this demand is genuine, while some is artificial; but it is there. There are more consumers of medical care than ever before in our history, and medicine has more and more to offer these consumers. Health education by the mass communications media has made the public health-conscious and knowledgeable as never before.

Remarkable strides have been made in expanding existing medical schools and in founding new ones. From 77 medical schools in the World War II era, we are moving toward 105 by 1975. At this time our total of M.D. graduates will have increased to 10,500 or more annually.

This notable achievement has required the active and constant support of American medicine and substantial sums of money from AMA dues and from AMA-ERF. This physicians have cheerfully contributed in meeting our responsibilities, because the procreation of a profession is something which cannot successfully be delegated to others.

The delivery of medical care is the topic of the times; nearly everyone is writing and speaking today about delivery systems. Perhaps we are lacking in definition, and, certainly, there is no universal uniformity among those who discuss it. But if we are talking about the application of science to the benefit of the patient, the circumstances under which care is rendered, or merely the manner of meeting for the physician and patient, then we have a broad spectrum to consider.

PARTIES INVOLVED

Initially, there are two parties—and two only—involved in delivery of medical care, the physician and the patient. But in the course of social evolution, society inevitably became more and more complex, as did financial structures, conditions of employment, and the insuring of hazards—including health care.

It is my feeling that there is room in this country for all types of delivery systems provided these systems arise out of a local need in a normal evolutionary way. What we cannot afford is to have the greatest medical system in the world destroyed by theorists who would overnight impose upon us rigid and unproven systems.

Under our present system, life expectancy has been greatly extended and the cost of illness overall has been reduced dramatically when figured in man-hours of work required to purchase cure of a given disease.

We must continue to study this problem of delivery systems and adopt only those methods that have been tested and proven to increase efficiency and offer mutual satisfaction to the parties concerned. We must constantly strive to render more and better service at less cost, never losing sight of the fact that medicine is a very personal service and it should ever remain so.

I disagree with the implications of some outside planners that they know more about medical quality and medical delivery systems than the medical profession itself. Let me point out a statement made by Dr. Ed Annis: "Who was it who rid the nation of diploma mills and elevated the standards of medical education in this country to the highest in the world? Who developed tissue committees and medical audits and other quality controls to improve the practice of medicine for the benefit of the people? Who established specialty boards to insure competency in the various specialties? Who developed a Code of Ethics to guide the conduct of doctors, and who imposes strict discipline on the medical profession? Who developed Grievance Committees to protect the public against the occasional physician who gouges his patients or otherwise abuses his trust? The Federal Government? No! The medical profession; and let me remind you that these actions and many others have been voluntary—the deeds of a profession which has recognized its public responsibilities and has discharged them well."

VIEWPOINT AND EVOLUTION

Government programs are a fact of life, and we who know most about medical care must constantly work to channel these programs in the right direction. We debated the Medicare program for about 15 years and, in my opinion, the final product is the best government medical program ever devised. It is an example of how a satisfactory program can evolve through careful and necessarily lengthy study and discussion. The program has some features that need to be modified, but it does provide those basic features that are of the utmost importance.

PROGRAM FLEXIBILITY

It allows freedom of choice of physician, and the physician deals directly with the patient. It provides direct billing. The physician simply gives the patient an itemized bill which includes the diagnosis and the procedure performed. This he would do anyway, so costs are not increased. If assignments are preferred, this can be accomplished at minimal effort with the same information. Remuneration is on a usual and customary basis—the only just basis. There is no disturbance of the doctor-patient relationship. We must be ever alert to see that these features are not disturbed.

A year ago, Dr. Temple Ainsworth, in discussing some of these same problems, observed that "he who fails to respond to the challenge will not be a factor in the change." Medicine in Mississippi has been, and is, responding to the challenge.

We have long agreed that we ought to face up to the fragmented programs of care for the indigent in our state which are inadequate, inequitable, and overlapping. We have called for a searching reappraisal and an updating of these programs. We were offered this opportunity, and we have done something about it.

In the enactment of the Comprehensive Health Planning Act and the succeeding Partnership for Health Act, the Congress offered the states an opportunity to make reappraisals and to marshal their health resources along the lines which seemed best for each. As at no other time in the past 35 years, we are taking a hard look at our almost totally uncoordinated health care programs.

The voices of our State Medical Association and the practicing profession have been strong in these endeavors. If nothing more, this is the achievement of 1968-1969. But it is not enough to make an opening move in meeting the challenge. It is up to each of us as individual physicians and jointly as a medical association to pursue the effort and to keep our voices strong.

We cannot, we dare not do less. With imagination and courage, we can do much more. ★★★

512 Van Buren Ave. (38655)

ADDENDUM

(When submitting his manuscript for publication, Dr. Rogers included a sample form on the individual responsibility program which, he points out, "could be modified as the individual physician desires." He emphasizes that the concept of the program has been approved by the House of Delegates and that it is optional and voluntary. The form presented by Dr. Rogers is for information in response to the action of the House of Delegates and many requests which he has received since the 101st Annual Session.—*The Editors)*

INDIVIDUAL RESPONSIBILITY PROGRAM TO OUR PATIENTS

IF YOU INTEND TO SEEK REIMBURSEMENT FOR PROFESSIONAL SERVICES FROM ANY INSURANCE COMPANY, PLEASE NOTIFY THE SECRETARY OR RECEPTIONIST PRIOR TO YOUR VISIT WITH THE DOCTOR.

The expense and time involved in preparing reports and claims for our many patients who are covered by some sort of medical insurance have reached the point where they must affect the cost of your medical care. This is not medical expense and should not appear as one. Some standard method of procedure must now be used if we are to prevent "paper work" from seriously interfering with your doctor's prime mission—the care of the sick. This is the purpose of the Individual Responsibility Program.

If you intend to make a claim on any third party for the cost of your medical care, please request the *Attending Physician's Statement.* We will gladly supply this form at no cost for you to file your claim for reimbursement for your monetary loss due to illness. We believe it will be entirely satisfactory to most insurance companies. Should your insurance company require additional information, we will supply it for an appropriate fee from the inquirer and on receipt of proper authorization.

Each patient will be responsible to the doctor for payment of charges for medical expenses, and may make any arrangements he might choose with his insuror. In this way, the relationship between patient and his doctor will remain private, as it should be, and the same is true of the relationship between a patient and his insurer.

If you experience any difficulty in settling your claim, contact your insurance company directly.

YOUR DOCTOR

The above is a sample form. This could be modified as the individual physician desires.

IN AN UNACCUSTOMED MANNER

"Young man, do you think you can support my daughter on $40 a week?"

"I'm willing to try, sir, if that's the best you can do."

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I
NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II
PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws. to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a non-profit organization.

Article III
COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV
MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, or emeritus, acording to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate shall be construed as active in connection with the rights and privileges accruing therefrom.

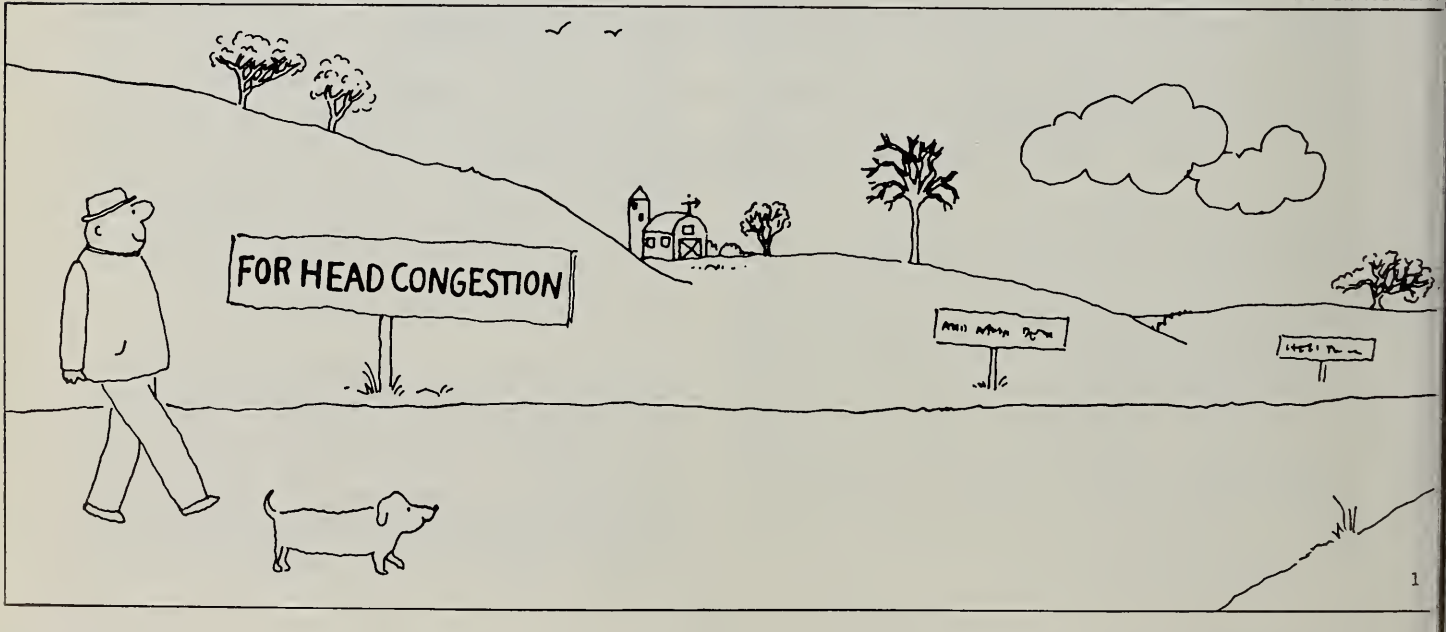
Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V
SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

ADVERTISEMENT



Article VI

GENERAL OFFICERS

Section 1. The general officers of this Association shall be a President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend two-thirds of the past two and current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII

EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII

HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association, members of the State Board of Health, and members of the Board of Trustees of Mental Institutions, all of whom must be members of this Association.

Article IX

BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of nine members, one from each Association District, elected for terms of three years each. A Trustee shall not serve more than three consecutive terms.

Article X

FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI

THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII

AMENDMENTS

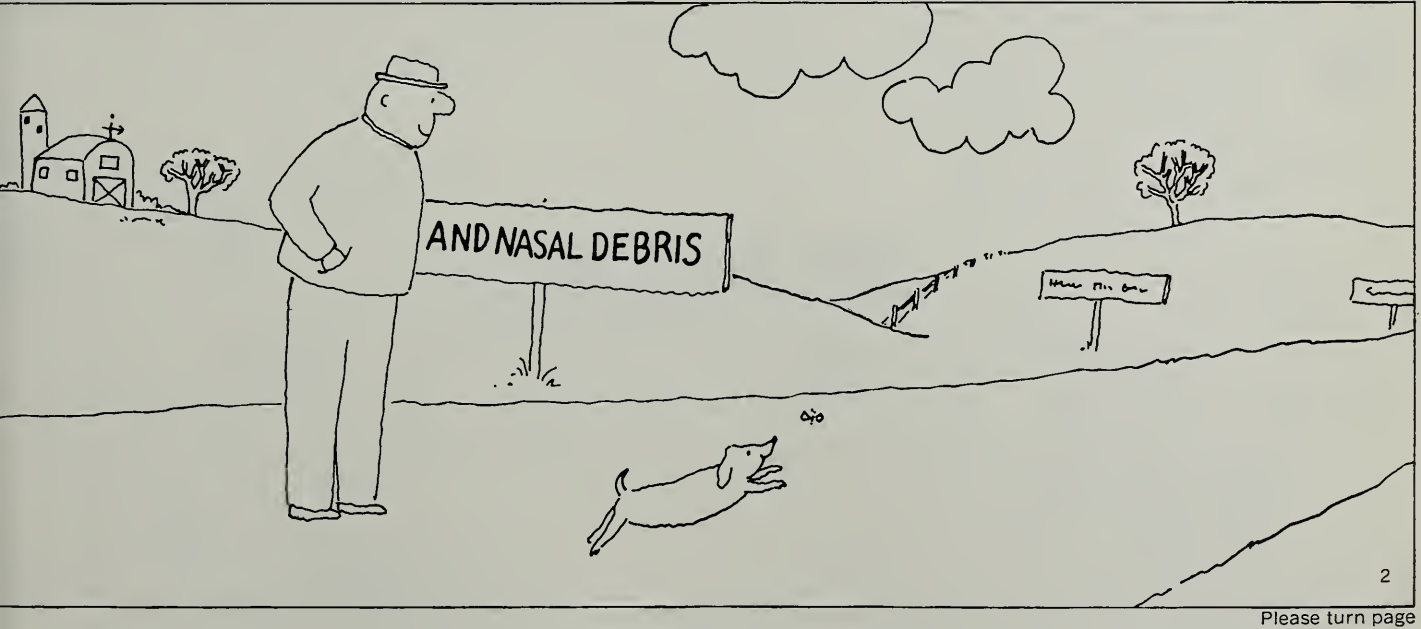
The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

BY-LAWS

Chapter I

MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the



Please turn page

qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement.

Section 2 (a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association. (c) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any members of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reason of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ of the Veterans Administration, not licensed to practice in the State of Missis-



sippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hospital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar ($5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this Association shall pay the dues or hold a legal exemption from the dues of the American Medical Association. These dues shall be paid through the component society to the Executive Secretary of the Mississippi State Medical Association, whose duty it shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II

ANNUAL AND SPECIAL SESSIONS

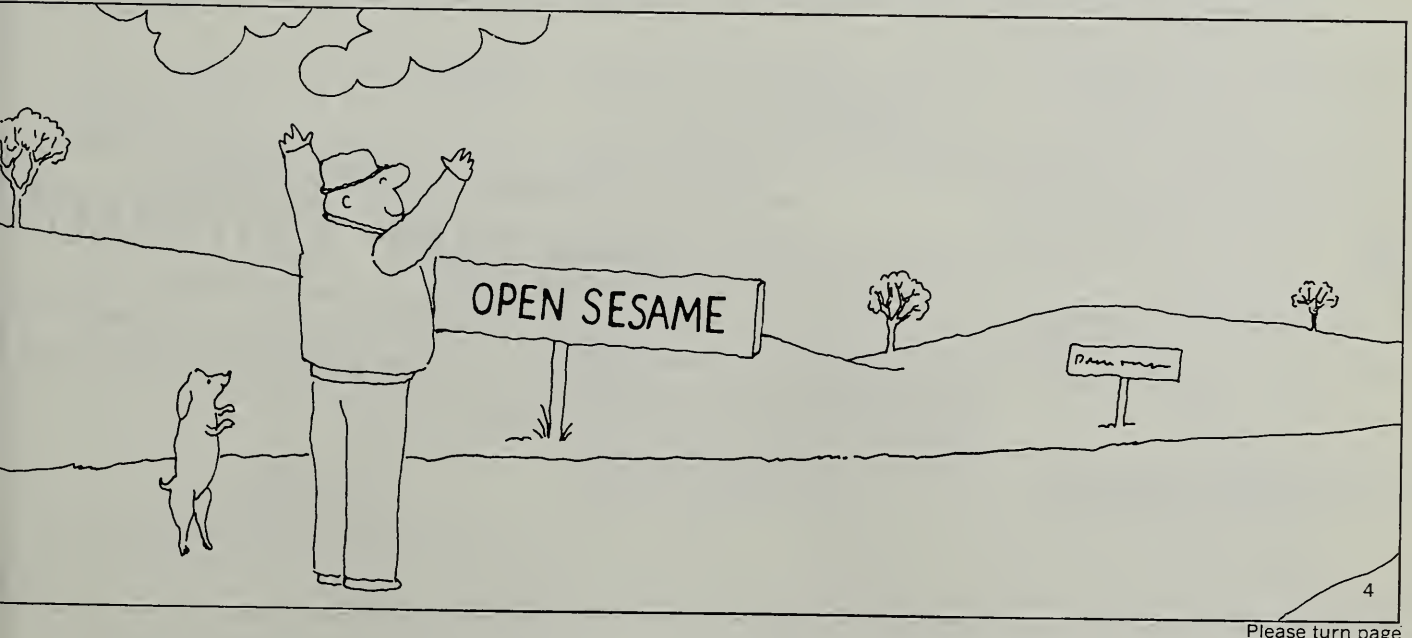
Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association. which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) Invited guests
(e) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
(f) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive



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Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.

(g) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III

GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a section of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV

SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, and (g) Section on General Practice.

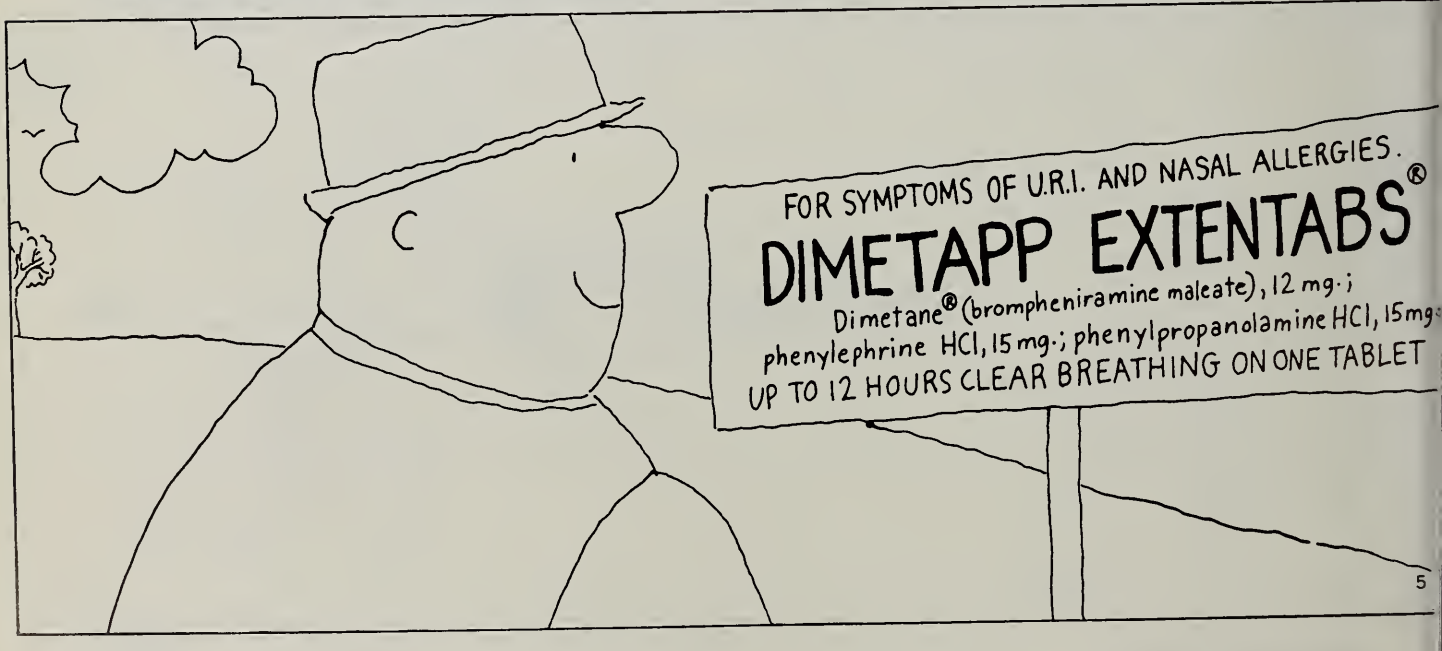
Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V

HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each



organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Robert's Rules of Order, Revised,* and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

(1) Adoption of the Transactions of the previous meeting.
(2) Reports of Boards, Councils and Committees.
(3) Reports of Presidential Committees.
(4) Special Orders.
(5) Unfinished Business.
(6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county in the state has been brought



INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening.

SUPPLIED: Bottles of 100 and 500.

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under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI
ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Missouri State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms. The House of Delegates shall nominate five physicians when vacancies occur on the Board of Trustees of Mental Institutions which nominations shall be submitted to the Governor in accordance with law.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII
DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex-officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devolve the duty of bringing before the House through the various officers and chairmen all reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex-officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions

and meetings of the Association, the House of Delegates, the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII

BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of nine members, one from each Association District, where terms of office shall be three years and so arranged that only three members are elected annually. A Trustee shall not serve more than three consecutive terms. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

District 1:	Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica. and Washington.
District 2:	Benton, DeSoto, Lafayette, Marshall, Panola, Tate, Tippah, Union, and Yalobusha.
District 3:	Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, and Tishomingo.
District 4:	Attala, Carrol, Choctaw, Grenada, Holmes, Montgomery, and Webster.
District 5:	Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Smith, Warren, and Yazoo.
District 6:	Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.
District 7:	Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, and Wayne.
District 8:	Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.
District 9:	Hancock, Harrison, Jackson. and Stone.

Chapter IX
COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service. a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than three consecutive terms.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Occupational Health, Maternal and Child Care, Mental Health, and Blood and Blood Banking. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion. censure. suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of three members elected by the House of Delegates for terms of three years each. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X
COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Grievance Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Grievance Committee. The Grievance Committee shall be appointed by the President with the advice and consent of the Board of Trustees. Its purpose shall be to prevent or resolve misunderstandings, to clarify and adjust differences between physician and patient, and to assist in maintaining the high levels of professional deportment already established by the *Principles of Medical Ethics*. The committee shall consist of nine members, one from each Association District, appointed for terms of three years each so as to provide

for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary or appeal body of the Association or its component societies. The committee shall have authority to compel a response either in writing or by personal appearance from any member of the Association, authority to initiate investigations on its own motion, and authority to file charges in the name of the committee before the Judicial Council of the Association. Under no circumstances shall the Grievance Committee ever exercise a disciplinary function and its power and authority shall be limited to the receiving of complaints, conduct of investigations, hearings, mediation, arbitration, and where necessary, referral of matters to appropriate bodies for adjudication or discipline. The committee shall prescribe its rules for operation which shall not be in conflict with generally accepted guides promulgated by the American Medical Association.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official Journal of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the Journal, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Chapter XI
RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII
COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII
FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV
AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV
REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.



The President Speaking

'Politics: Not a Dirty Word'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

IMMEDIATELY following the MSMA convention in Biloxi, your president with four other members attended the AMAPAC work shop in Washington. Our delegation was led by Dr. Howard A. Nelson, chairman of the Mississippi Medical Political Action Committee. There were over 700 physicians, from all the 50 states, in attendance, eagerly attentive to the most interesting discussions of American politics and to the important role that organized medicine can and does play. We were told by several unbiased national authorities that AMAPAC, with its many active state political action committees, is the most effective organized political activity in America today.

It is only in the last three or four years that doctors in large numbers are awakening to the reality of the American political system and the great need to play a major role. Even though organized medicine is vastly more effective politically now than in former years, we still have hardly scratched the surface of the enormous potential that a truly unified and organized medical community could achieve.

Whether we like it or not, government is deeply involved in medical affairs. The type and degree of this involvement is the subject of many controversies, but few would argue that it is the duty of big government to be deeply concerned regarding the health of the people. It is urgently necessary that doctors become deeply interested in public and political affairs so that they may lead in developing government attitudes and legislation, rather than being led by others down the road that we know to be not in the best interest of patient and doctor.

Even the most dedicated practitioner of medicine—including the remote full time researcher in the exciting frontiers of medicine—must recognize the reality of the need for doctors to exercise their leadership in socioeconomic and legislative affairs. Politics is not a dirty word. Physicians and their wives belong in political affairs. It has been said that the fact of change is the most changeless thing. We must influence these changes or be adversely and irreversibly changed by those outside the medical community. ★★★

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EDITORIALS

Prescription Drug Substitution: Old Problem With New Faces

I

MORAL AND LEGAL obligations upon the pharmacist make him a fiduciary of the patient. In the words of Professor Sidney Willig, director of the Drug Law Unit of Temple University, "He is the knowing one, and they the unknowing insofar as ingredients and products are concerned. They look to him to insulate them against subpotency or deterioration, and it is his integrity that guides the dispensing act."

Substitution in dispensing a prescription, then, is not just a departure from the principle of *secundum artem,* it is plainly illicit and unauthorized. So strong is the obligation to dispense exactly what the physician prescribes that there is no organized pharmacy group in the United States which has not subscribed to the strongest pledge against it. So there can be no valid argument excusing substitution where ingredients of a specific chemical or biological identity are replaced in the dispensing act by those of a different chemical or biological identity.

But the pharmacist no longer labors to any significant extent over the marble slab with his mortar and pestle. His inventories represent the latest strides of science with dosage units of every shape, size, and color. So, as Professor Willig has pointed out, the traditional significance of substitution must now take into account the scientific achievement of pharmaceutical manufacturing. The drug maker takes the responsibility for his product, often standing as its innovator, warrantor, and marketer. So when the physician has made his choice in his prescription by brand name, there is no possible or permissible substitute. And the ethical pharmacist is the first to agree.

II

The eyewash of generic equivalents is poured out of the halls of the Congress, government agencies administering medical care programs, and even occasionally from our friends in the health insurance industry. The only true generic equivalent, for example, is aspirin for aspirin, and this is not necessarily so, what with binders, dosage form, stability, and a host of technical factors entering the picture.

The Mississippi State Medical Association, acting in response to the professional judgment of its members, believes that the physician should be free to prescribe by brand or generic designation, according to his choice in the therapeutic interests of his patient. Substitution is therefore an ultimate injury to the well-being of the patient.

While there are state laws aplenty prohibiting substitution, there is literally no mention of it in the Federal Food, Drug, and Cosmetic Act or in the important Durham-Humphrey Amendment which defined over-the-counter and legend drugs. But the intent and teeth are there, because the

mislabeling clause takes care of substitutes, counterfeits, and imitations.

There is an important thread of legal continuity in that a pharmacist's inventory of legend drugs are suitable, under federal law, for use only according to a physician's prescription. This is inflexibly defined in the interest of the public. Moreover, regardless of absence of criminal intent, accident, or negligence, the pharmacist is held to strict accountability for his inventory of legend drugs.

In a key decision in 1948, *U. S. v. Sullivan,* the United States Supreme Court held to be criminal "the doing of any other act with respect to a food, drug, device, or cosmetic, if such act is done while such article is held for sale after shipment in interstate commerce and result in such article being misbranded."

It therefore makes no difference if a pharmacist, in dispensing a legend drug *not* ordered by a physician, follows the format of the FDA Act, uses a prescription label, assigns a number, and makes a record; he has misbranded his prescription under federal law, and the substituted product is subject to seizure.

III

The law says that substitutes may be counterfeits and imitations, but this is not always true. For example, a counterfeit is always a substitute, whereas the imitation simulates the genuine article without necessarily duplicating its appearance, as does the counterfeit. So if a drug substituter were to use counterfeits or imitations for the substitution, he compounds his wrongful act. He is possibly aiding and abetting in a fraud.

Some legal authorities believe that state pharmacy laws ought to be amended to provide severe penalties for substitution with a counterfeit drug. Here is the rationale: When a counterfeit substitute is used, it is the dispensing act which qualifies it as a successful counterfeit, since at that point, it is passed for the real McCoy.

The authorities argue that state law ought to require the name of the drug on the prescription label. This would establish vulnerability of the substituter to prosecution by patient, government, and the real drug's manufacturer. But the name would have to be that written by the physician in the prescription, or the substitution would be only that of chemical nonequivalents.

The disclosure on the label raises questions on physician-patient relationship and those on self-medication. The position of the state medical association is that the pharmacist should disclose the drug identity on the prescription label only when the prescribing physician so directs.

IV

Professor Willig warns that there is danger in substitution for the prescribing physician. The courts recognize that medicine is not an exact science and that the physician is not a guarantor of therapeutic results. So nonsuccess in treatment of a patient or a therapeutic accident are not necessarily *per se* negligence or malpractice. In fact, the courts have held that the physician whose patient becomes pregnant after he has prescribed birth control pills is neither liable for the failure of the pills in that particular patient nor for the accident of conception.

But patients who experience unsatisfactory therapeutic results are sometimes inclined to initiate civil proceedings. While the likelihood of success is not substantial, there are still expensive and time-consuming legal processes to be undertaken. For this reason, Professor Willig continues, "physicians eye askance any procedure that by civil or criminal infraction, or through the color of misconceived authority, may militate against the desired and anticipated results of prescription."

So substitution in dispensing legend drugs is an old problem with new faces. Happily, a vast near-unanimity of pharmacists detest and eschew this unwholesome practice. So even if it were like death from the common cold, to him whom it happens, the mortality is 100 per cent.—R.B.K.

Womanpower May Be the Answer

Brace yourself for this one, because it may come as a shock. By 1975, says the Health Insurance Institute, health care will be the nation's largest "industry" in terms of expenditures and individuals engaged in it. By that time, according to HII, reliable estimates peg the total engaged in all phases of health services at 5.3 million Americans. The bill will be $94 billion a year.

At the moment, health care ranks third in single identifiable endeavors, coming in only behind agriculture and the construction industry in terms of the total engaged. By comparison, the automobile industry, certainly one of the most visible,

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The improved model you prescribe today is still made with the same painstaking devotion.

When your patient is in the grip of bronchospasm and reaches for his Medihaler, it must work. Not sometimes. Not most of the time. *Always.*

This is the ideal of perfection which has motivated the constant process of improvement of Riker's Medihaler.

Since its invention in 1956—when a Riker physician developed the Medihaler because of his determination to make better treatment available for his own asthmatic child—Riker has pioneered just about every significant forward step in bronchodilator aerosol therapy.

Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

Riker was first to formulate medication in a non-irritating, non-alcoholic vehicle.

Riker pioneered pre-grinding of the medication to 1-5 micron size, assuring maximum distribution to the distal bronchioles for greater topical effectiveness with less systemic action. (Oddly, even today not all competitors have adopted these two advances.)

Add to these advantages a quality control system involving 168 physical measurements and chemical tests, plus not one but two test firings on every single unit leaving the plant, and you can readily see why there is no more dependable relief for bronchospasm than your prescription for Duo-Medihaler or Medihaler-Iso.

Please see next page for complete prescribing information.

Medihaler-Iso®
(isoproterenol sulfate)



Duo-Medihaler®
isoproterenol HCl (4mg./cc.)
phenylephrine bitartrate (6mg./cc.)

Riker Laboratories, Northridge, California 91324

The Riker Representative in your area is: Dalton Johnson

SUMMARY OF PRESCRIBING INFORMATION

DUO-MEDIHALER®

(isoproterenol hydrochloride and phenylephrine bitartrate)

Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Northridge, Calif. 91324

amounts to a $50 billion annual gross, actually less than health and medical care. But the growth rate in health services in totals engaged is astonishing: From 1961 to 1967, the total rose to 3.7 million from 2.7 million.

The experts believe that the field would be growing more rapidly if additional women could be attracted to health careers. There are twice as many women in health services in France than in the United States, two and a half times as many in Great Britain, and three times as many in West Germany. Maybe womanpower is the final solution to the problems of medical manpower.—R.B.K.

The Unspeakable Alternative to Medicaid

As the special session of the Legislature on Medicaid approaches, we need to remember the prophetic words of Dr. James T. Thompson of Moss Point in his 1967 presidential address. His subject was Title XIX Medicaid, and he laid it on the line. Perhaps his warning would have been appropriate in the major article on the program in this issue (*Day of Decision: Medicaid for Mississippi?*, page 291), but observing the ground-rule that editorial opinion belongs on the editorial page, this view appears separately.

Dr. Thompson reviewed the wide range of fragmented, inadequate programs of health care for the indigent which, like Topsy, have sort of growed in Mississippi. He pointed out how the three-way, $5 million appropriation for the State Hospital Commission, for the four charity hospitals, and the Cerebral Palsy Hospital School—all 100 per cent state tax funds—could be matched under Medicaid to generate about $28 million annually.

He was careful to point out that the association isn't trying to abolish and destroy, and he recalled that on more than one occasion, the association had spent its own money and effort to pull the State Hospital Commission's legislative chestnuts out of the fire. He recalled that the association devoted four years to a futile effort to bring quality teaching programs to the charity hospitals in an attempt to improve care.

But he said that there ought not to be any sacred cows where the health of the people is concerned, and he warned that the unspeakable

alternative to Title XIX Medicaid is an OEO regional or neighborhood health center on just about every street corner and at every crossroads.

The Tufts-Mound Bayou project is the case in point. OEO is pouring just under $4 million a year into this "community action" program which at best serves a tiny segment of the needy population. *The expenditure is half of what would be needed by the state to implement a $41 million Medicaid program for 202,000 citizens in every county of the state.*

Direct-action programs such as the Tufts-Mound Bayou project by-pass all levels of local government, the state medical association, the component medical society, and everyone except the sponsors themselves. We need to bring Dr. Thompson's sound advice into sharp focus and think in terms of the private care delivery system.—R.B.K.

The Tight Dilemma of Hospital Costs

The hospital cost-price squeeze becomes more acute by the day, and present cost levels suggest no reason to disbelieve the experts who predict that the tab will hit $100 per patient day by 1975. This is a gloomy outlook even if the shrinking dollar were to stabilize today. But the nation remains in an inflationary spiral, ranging between 7.5 and 9 per cent per year. As a problem demanding high national priority, it ranks just behind the war in Viet Nam and the domestic issue of law and order.

The American Hospital Association has adopted a sweeping new policy position on hospital care costs which says that every patient should be required to pay the true costs of services he receives plus a fair share of overhead, education, and research costs of the institution.

The *quid pro quo,* the AHA policy continues, is for the hospital to adopt fair and open pricing schedules and to turn its future over to the community as regards expansion and new programs. AHA explains that "in essence, the statement declares that the community must provide for proper financing of its health care system and that the health care system must accept, on its part, the community's right to insist on proper planning within that system."

Those within AHA who differed from the majority adopting the position argue that hospitals would be unduly restricted in placing their plans for expansion in the hands of community agencies. Still others point out that Medicare and other government programs decline to ante up costs of education, research, and overhead. In fact, Medicare has already stripped away the 2 per cent capital depreciation allowance, to the dismay of hospitals.

Although there are many quantities in the hospital cost equation, the price of people—skilled personnel in the allied professions and technician categories—remains the crucial item. Apparently, little can be done in this respect, especially in view of personnel shortages.

The tight dilemma of mounting hospital costs is a reason for real concern, and every member of the health care team should address his best effort toward penetrating the mystique and maze of problems surrounding this critical circumstance. —R.B.K.

Well-Represented, by Mr. Brown

Directly and indirectly, the JOURNAL has received various recognitions, but a recent indirect honor makes us proud. Our Chicago advertising sales chief, Monte Brown, was named the second annual Space Representative of the Year and received a special plaque and an honorarium of $500. The award is sponsored in behalf of the advertising industry by Sieber and McIntyre, a major agency.

National advertising for the 34 state medical journals is sold through the State Medical Journal Advertising Bureau, an Illinois corporation which is owned by the 34 state medical associations. In turn, SMJAB contracts for sales representation with Medical Media Associates, Inc., of Chicago and New York of which Mr. Brown is a partner. Thus, the JOURNAL is represented every day by a number of able sales executives calling on major pharmaceutical manufacturers and their advertising agencies.

To have our man in Chicago so recognized by the ad industry is also a pat on our back as to the quality of sales integrity and creativity we have. We congratulate Mr. Brown on this singular honor and feel pretty good about our choice of sales representation.—R.B.K.

LETTERS

SIRS: After one and a half years in sunny Thailand, our family is being reassigned to Fort Leavenworth, Kansas, where I will be privileged to command Munson Army Hospital. This is considered to be a prestige assignment since it is the home of the Army Command and General Staff College. Naturally I am most pleased to be going there, and the family is looking forward to returning to the States.

The tour of duty in Thailand has been most interesting and a real education for every member of our family. The children have been particularly impressed with this view of life on the other side of the world. We took advantage of the opportunity to visit throughout the entire country while here and took a trip to India as well. This has provided insight which could never have been gained by poring through a book.

Disease trends here are not so much different from Mississippi. Upper respiratory illnesses constitute the major cause of lost man-hours, with gastrointestinal diseases running a close second. Tuberculosis is still a problem among the "hill-tribe" people where it is conservatively estimated that 25 per cent of the population are ppd positive. Malaria is prevalent in the mountainous areas, but is virtually non-existent in the Bangkok area where we live. Our biggest problem here, as in Vietnam, is with Falciparum type malaria. While we have few cases, comparatively, it responds poorly to treatment. We use chloroquine-primaquine weekly, and in some areas, dapsone daily as prophylaxis, which has been quite successful.

We have some excellent treatment facilities for U. S. citizens in Thailand. Several completely staffed hospitals, air conditioned and beautifully equipped, are located throughout the country. It has been my privilege to direct the U. S. Army medical activities in the year and a half I have spent in Thailand. This has provided an excellent opportunity for me to grow in medicine. What an education I have had! Fortunately, the fifteen years spent in general practice in Mississippi had prepared me in a way for what we have encountered here in diagnostic and therapeutic problems, so we have managed to stay ahead of things satisfactorily. I never before realized how much I am indebted to the many fine physicians in Mississippi who provided guidance and en-

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Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

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Assistant Professor of Psychiatry and Medical Director

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couragement in the formative years of my practice. My thanks and admiration grows with the passing of each day.

ALBERT L. GORE
COLONEL, MC, USA
FT. LEAVENWORTH, KANS.

PERSONALS

JOHN F. BUSEY of Jackson has been appointed director of medical education for Mississippi Baptist Hospital. Dr. Busey, a native of Alabama, has served as chief of medical services at the Jackson Veterans Administration Hospital since 1950.

THOMAS PURSER, III, MARION M. WINKLER, JR. and CHARLES THARP, all of Tupelo, were honored at the noon luncheon on Doctors' Day at North Mississippi Medical Center. The event signaled the close of National Hospital Week.

VERNER HOLMES of McComb has been appointed chief of staff of the Southwest Mississippi General Hospital. Dr. Holmes, who is currently serving his second term on the board of trustees of Mississippi's institutions of higher learning, limits his practice to otorhinolaryngology.

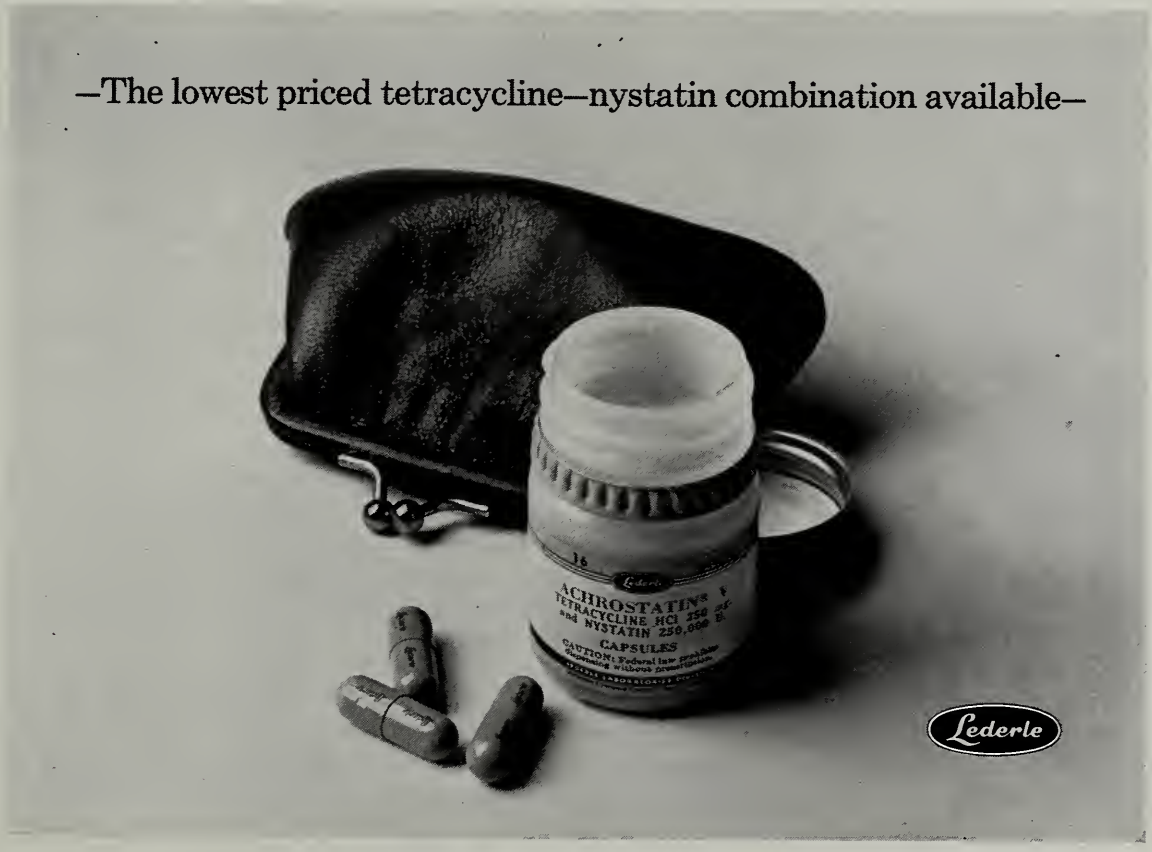
EUGENE MURPHY, III, of Tupelo received the Mississippi Heart Association's Gold Award for outstanding service at the association's 18th annual assembly in Jackson.

PERRIN L. BERRY of Jackson has announced the removal of his offices to 755 East Fortification Street, corner of North and Fortification.

CURTIS W. CAINE of Jackson recently addressed the Central Mississippi chapter of the Mississippi Association of Medical Assistants. His topic was his AMA-sponsored trip to Vietnam.

DAVID B. WILSON of Jackson was featured speaker at the dedication of McComb's new Southwest Mississippi General Hospital. Dr. Wilson is director of University Hospital and past president of the American Hospital Association.

J. P. MCLAURIN, JR. of Oxford has been reelected alderman of ward one in the recent municipal elections.



W. Richard Campbell and Thomas B. Whitehead of Columbia have announced the transfer of their office to the Family Clinic, 502 Broad Street.

Maxwell D. Berman of Jackson has written his first non-professional book, *The Solution,* which has been published by the Carlton Press, Inc., of New York. The author chose a fictitional Mississippi boy, Joe Blake, to solve all the world's problems.

James E. McAfee of Cleveland has become an associate of the Cleveland Clinic. His partners in the general practice of medicine there are S. D. Austin, Arthur Lindsey and John Milam.

G. Swink Hicks and Leo Scanlon of Natchez recently participated in a three-day American Medical Association workshop in Washington, D. C. Both are members of the AMA's Political Action Committee.

S. Ray Pate of Vicksburg has announced the opening of his office in the Messina Clinic Building at 1411 Cherry where he limits his practice to psychiatry.

Temple Ainsworth of Jackson chaired a panel on federal and state aid to the state kidney programs at the Mississippi Kidney Foundation's fourth annual meeting in Jackson.

W. N. Crowson of Clarksdale has moved the Surgical Clinic from the Medical Arts Building to 1819 Hospital Drive.

Robert Abney and William A. Long of Jackson and William J. Carr, Jr. of Gulfport have been elected to fellowship in the American Academy of Pediatrics.

Robert L. McKinley, Jr. of Tupelo recently addressed a guidance counselors' institute at the North Mississippi Medical Center.

Jessie Mauney of Blue Mountain has been named Blue Mountain College Alumna of the Year. Harold Fisher, college president, presented the award to Dr. Mauney.

Henry J. Kellum, Jr., of Tupelo has announced his reassociation in the practice of internal medicine with his father and brothers in the Kellum Clinic, 500 North Gloster Street. He was formerly health officer for Tippah, Union and Pontotoc counties.

Kenneth D. Terrell of Prentiss, David D. Richardson of Louisville, John M. Patterson of Pontotoc, Harry Fridge of Hattiesburg, James P. Guerriero of Vicksburg and William A. Middleton of Winona have been re-elected to active membership in the American Academy of General Practice. All were required to complete 150 hours of accredited postgraduate medical study in the last three years.

Guy Campbell and T. D. Lampton of Jackson recently addressed hospital officials of the Gulf Coast area on Regional Medical Programs in Mississippi. Establishment of a regional coronary care system in the hospitals of Harrison, Hancock and Stone counties, with MRMP aid, was discussed.

Frank K. Tatum of Tupelo and Hugh B. Cottrell of Jackson were featured speakers at the 50th anniversary celebration of the Lee County health department.

Edward R. North of Jackson participated in the Northwoods Exchange Club's annual charity horse show May 10.

John Busey and Guy Campbell of Jackson and Robert E. Schwartz of Hattiesburg represented Mississippi societies at the annual meeting of the National Tuberculosis and Respiratory Disease Association in Miami Beach. Approximately 2,500 health team members attended the 65th session.

William T. Oakes of Amory and his wife attended a postgraduate course in general medicine and surgery aboard the M/S Boheme. The course, sponsored by the Alabama Academy of General Practice, included visits to the Bahamas, the Virgin Islands and Puerto Rico.

John Bower of Jackson spoke at the May meeting of the West Mississippi Medical Auxiliary. The UMC assistant professor discussed diseases of the kidney.

Roland E. Toms of Jackson has been named regional representative to Wayne State University's School of Medicine Alumni Association. As regional representative, he will join other representatives in alumni association policy-forming sessions in Detroit.

Estelle Magiera and Jerry Ross of Jackson will address the 14th annual Preschool Teachers' Workshop at the University of Southern Mississippi on mental and emotional health July 14-18.

Robert McBroom of Pascagoula announces the opening of his office at 224 South Pascagoula Street where he will limit his practice to internal medicine and gastroenterology.

Thomasina Blissard of Jackson announces the opening of her office at 605 Medical Tower for the practice of psychiatry.

Jack Q. Cash, formerly of Senatobia, has joined the staff of the South Panola Hospital in Batesville as associate in medicine and surgery. Dr. Cash is a graduate of the University of Arkansas School of Medicine.

Donald R. Rayner of Long Beach has been re-elected vice president of the board of directors for the Gulf Coast Symphony Orchestra.

J. T. Davis of Corinth became president of the Mid-South Medical Association at its recent meeting in Memphis. Rhea L. Wyatt of Holly Springs was elected vice president of the association.

Robert Carter of Jackson and University Medical Center recently addressed the Hattiesburg Kiwanis Club. He spoke of the numerous contributions the medical school makes to Mississippi in the field of health.

NEW MEMBERS

The following physicians have been elected to membership by their respective component Medical Societies in the Mississippi State Medical Association and the American Medical Association.

Nealy, Wrendell Ré, Pascagoula. Born Homer, La., Oct. 30, 1931; M.D., La. State University School of Medicine, New Orleans, 1963; interned USPHS Hospital, San Francisco, Calif., one year; elected May 13, 1969 by Singing River Medical Society.

Ross, Joe Monroe, Jr., Vicksburg. Born Philadelphia, Miss., Aug. 15, 1937; M.D., University of Miss. School of Medicine, Jackson, 1964; interned Baptist Memorial Hospital, Memphis, Tenn., one year; medicine residency, same, July 1, 1965-June 30, 1968; elected Jan. 14, 1969 by West Mississippi Medical Society.

DEATHS

Anderson, William H., Booneville. M.D., Tulane University School of Medicine, New Orleans, La., 1918; postgraduate studies in surgery, Tulane, 1920, New York Hospital, 1925-26, and Mayo Clinic, 1926; postgraduate studies in obstetrics and pediatrics, Oct., 1945; chairman, Board of Trustees of Blue Mountain College; Board of Directors of the Mississippi Economic Council; co-founder of the MSMA Fifty Year Club; founder, editor and publisher of the *Mississippi Doctor,* official journal of the association for 36 years; president, MSMA, 1940-41; 1968 winner of MSMA-Robbins Award for outstanding community service by a physician; recipient of the Millsaps Award, 1967; died May 9, 1969, aged 83.

Charlton, Alton F., Itta Bena. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1909; postgraduate studies in obstetrics and pediatrics, Tulane University, Mar., 1945 and Mar., 1947; died May 6, 1969, aged 87.

Frazier, Thomas W., Crawford. M.D., University of St. Louis School of Medicine, St. Louis, Mo., 1916; interned St. Louis, Mo. University, three months; member MSMA Fifty Year Club; died May 11, 1969, aged 81.

Haslitt, Percy P., Ocean Springs. M.D., University of Illinois School of Medicine, Chicago, Ill., 1904; interned West Side Hospital, Chicago, Ill., one year; member MSMA Fifty Year Club; died May 19, 1969, aged 89.

O'Mara, B. B., Biloxi. M.D., Emory University School of Medicine, Atlanta, Ga., 1924; interned Davis-Fischer Sanatorium, Atlanta, one year; member of the Board of Directors of Blue Cross-Blue Shield, 1958-61; Fellow of the American Academy of Pediatrics; president of Coast Counties Medical Society; president, MSMA, 1949-50; original member of Committee on Publications, 1959-69; alternate delegate to AMA, 1953-69; vice-speaker of the MSMA House of Delegates, 1958-61; speaker of the MSMA House of Delegates, 1961-64; died May 24, 1969, aged 72.

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Construction Begins on New Addition to MSMA Headquarters Office Building

Ground was broken in June for the addition to the association's Central Office Headquarters Building at 735 Riverside Drive in Jackson. Construction will require 180 days, according to Dr. James L. Royals, president.

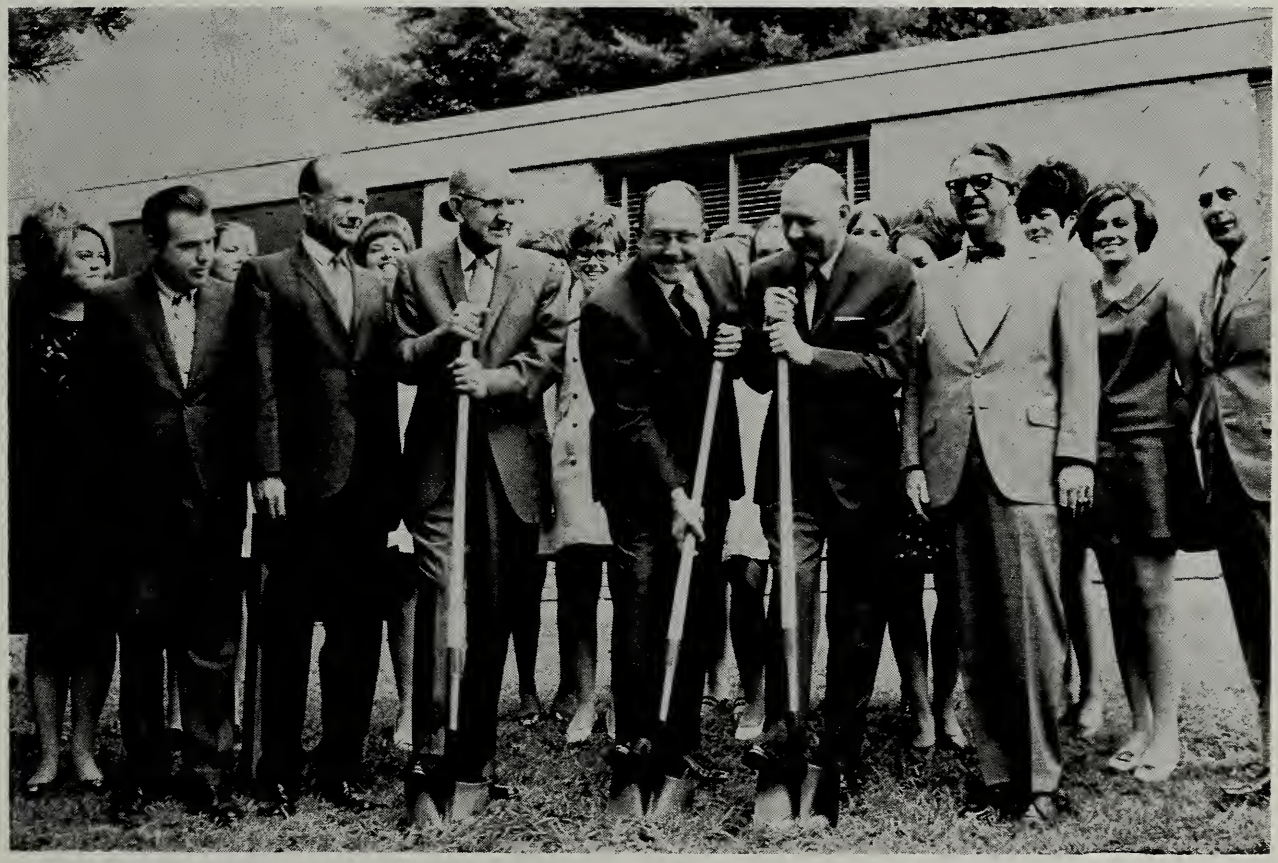
Successful bidder as general contractor was Priester Construction Co. of Jackson at $100,693 for the complete project. Second and third bids were respectively $100,811 and $107,681. The high bid of seven was $114,870.

W. R. Bob Henry, A.I.A., of Jackson, architect for the association, said that completion is estimated before Christmas.

The addition was initially authorized by the House of Delegates in 1967 but the project was deferred when the original architect, Jay T. Liddle, A.I.A., of Jackson died. Mr. Henry was retained in 1968 to complete planning studies and final plans and specifications.

Dr. Royals said that the new addition will be to the rear of the existing building, occupying two levels. It will provide almost 5,000 additional square feet of usable floor space.

Overseeing day-to-day details of the project is the Executive Committee of the Board of Trustees whom the Board designated as the Building



Breaking ground for the association's building addition are (center five, from the left) B. R. Summers of the Priester Construction Co., Drs. Paul B. Brumby, James L. Royals, William O. Barnett, and the architect, W. R. Henry, A.I.A. Members of the executive staff cheer the shovel-wielders on.

WHAT'S SO WEAK ABOUT THE WEAKER SEX?

Committee. The group consists of Drs. Mal S. Riddell, Jr., of Winona, chairman; J. T. Davis of Corinth; and William O. Barnett of Jackson.

The addition will furnish needed office space for the Membership Department, CHAMPUS Department, and the JOURNAL. At the lower level will be mechanical, storage, mail and mimeograph rooms.

The project also includes expansion of off-street parking, enlarging the existing facilities to accommodate 32 automobiles.

The association's property consists of 187 front feet on Riverside Drive which runs to a depth of 251 feet. It was purchased in 1954 for $12,500 and is now valued at $113,000 without the building and improvements.

The Building Committee has disclosed that there will be some renovation of the existing building which was dedicated at the Centennial Annual Session of the association in 1956. Interiors will be repainted and some repairs and replacements will be made.

Financing has been arranged by the Board of Trustees and the Council on Budget and Finance at the prime interest rate. The original building loan is to be paid out in 1971 and will not be refinanced. The initial amortization carries a 4.25 per cent interest rate which the Board was anxious to protect.

Breaking ground for the new project were Drs. Royals, Paul B. Brumby of Lexington, president-elect, and Barnett, the Jackson member of the Building Committee. B. R. Summers represented the contractor.

The new construction will be of the same quality as the original building with poured-in-place piling and slab-over foundations, steel framing, and masonry exterior. Interiors will consist of paneling, masonry, and dry wall construction with suspended ceilings and high intensity lighting. Floor covering will be vinyl and carpet.

The addition will accommodate foreseeable needs of the association for the future, Dr. Royals said. The total completed project will give the association approximately 12,000 square feet of usable floor space and storage.

The need for expansion was demonstrated in 1966 with action approving the project in 1967. The House of Delegates reaffirmed the authority given to the Board in 1968, and the Board reported to the House of the final plans at the 101st Annual Session this year.

Dr. Royals said that monthly progress reports on the project will be made to the membership through the JOURNAL.

Governor Gets Board of Health Nominees

Nine members of the Mississippi State Medical Association have been nominated to Gov. John Bell Williams for selection of three members of the State Board of Health. The nominees were chosen by written ballot at the 101st Annual Session.

Named to the governor for Public Health District 2 were Drs. G. Lacey Biles of Sumner, Julian C. Bramlett of Oxford, and John R. Lovelace of Batesville. Dr. Bramlett is the incumbent.

The six-year term, 1970-1975, is for the district covering the counties of DeSoto, Tate, Panola, Tallahatchie, Marshall, Lafayette, Benton, Tippah, and Union.

Nominees for District 4, covering Pontotoc, Chickasaw, Clay, Calhoun, Webster, Choctaw, Yalobusha, Grenada, Montgomery, Attala, and Carroll counties, are Drs. S. Lamar Bailey of Kosciusko, Thomas N. Braddock, Jr., of West Point, and Lester D. Webb of Calhoun City.

The incumbent member for District 4 is Dr. Joseph L. Guyton of Memphis, formerly of Pontotoc, who has been in a psychiatry residency.

Drs. Lamar Arrington of Meridian, John R. Laird of Union, and Omar Simmons of Newton are nominees for District 5. Dr. Arrington is the incumbent member.

The district covers the counties of Winston, Leake, Neshoba, Kemper, Scott, Newton, Lauderdale, Smith, Jasper, and Clarke.

The governor makes a selection from among three nominees for each vacancy, according to Sec. 7024, Mississippi Code of 1942, Annotated. The state medical association has the responsibility of making nominations.

Under association by-laws, the House of Delegates votes on six members for each vacancy, the three receiving the highest vote being the nominees. Notice of vacancies to occur are published prior to the annual session in the JOURNAL.

Other physician-members of the State Board of Health now serving are Drs. Dewitt Hamrick of Corinth, District 1; John G. Egger of Drew, District 3; Joseph G. McKinnon of Hattiesburg, District 6; G. Swink Hicks of Natchez, District 7; and H. C. Ricks, Sr., of Jackson, District 8. Dr. McKinnon is president of the board.

Dr. Hugh B. Cottrell of Jackson, the State Health Officer, is a member-at-large who is elected by the board. Other members-at-large are a dentist and an optometrist.

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Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
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Dr. Royals Urges Study of Medicaid

"No session of the legislature during the past quarter of a century has been more important to physicians than the July special session on Medicaid."

This was the assertion of Dr. James L. Royals, president of the association, who has underscored the crucial aspects of the medical care milestone in the state.

"I call on every member of the association," Dr. Royals continued, "to exert every effort to familiarize himself with the law and the proposals before the special session.

"I am especially hopeful that every member will read and study the major article in the July issue of our JOURNAL on the program. This article contains a policy review and many details of the proposal which are important to patients, physicians, and the entire private care delivery system," he added.

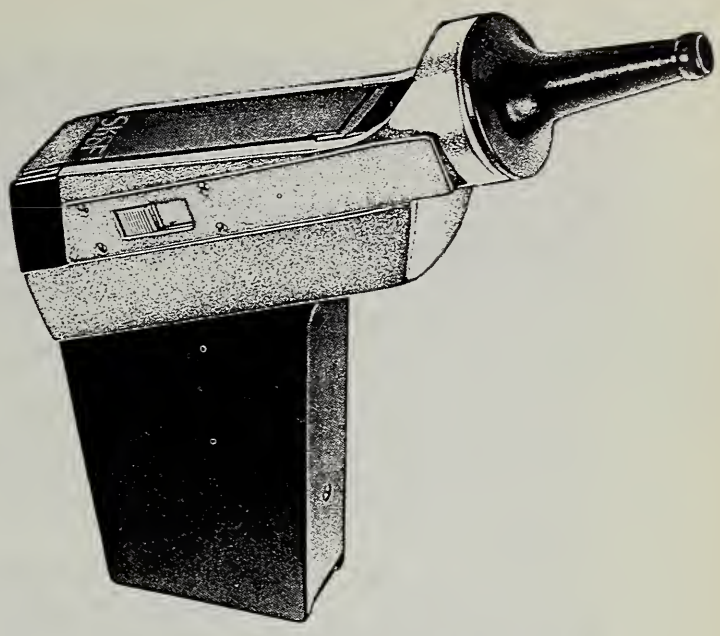
The association supports Title XIX Medicaid under a six-point positive program adopted by the House of Delegates in 1967. Dr. Royals indicated that the association will testify before committees of the House and Senate during the special session, outlining the association's position.

MHA Sets 38th Annual Convention

Mississippi Hospital Association members from throughout the state will convene at Biloxi's Buena Vista Hotel for their 38th annual convention July 9-11.

"Planning for the Future" is the theme of the conference slated to begin at 9:00 a.m. Wednesday, July 9. Academic sessions, group discussions and a host of exhibits will be featured attractions.

Distinguished guest speakers include Dr. Madison B. Brown, American Hospital Deputy Director, Chicago, who will take a look at the future; James E. Ensign, Blue Cross Association vice president, Chicago, who will discuss the Blue Cross-hospital relationship; Dr. John D. Porterfield, Director of the Joint Commission on Accreditation of Hospitals, Chicago, will consider the future impact of accreditation; Dr. Harald M. Graning, assistant surgeon general, HEW, who will take up future federal financing of hospital construction.



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Central Auxiliary Donates Medical Film

The Central Medical Auxiliary has donated a 28 minute color film titled "Horizons Unlimited" to the audiovisual library of the Jackson Public Schools.

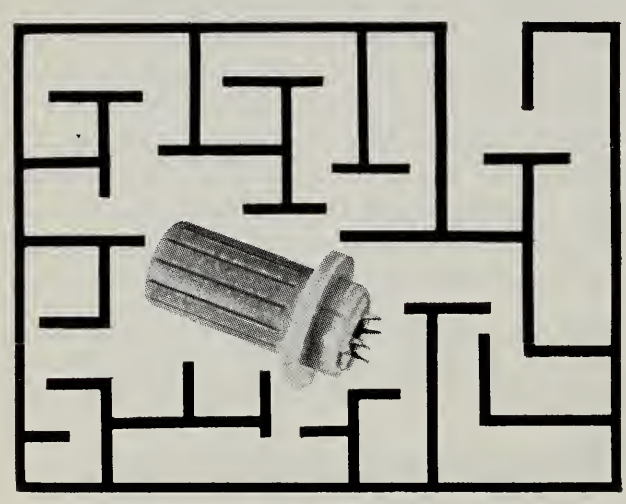
The film, which answers questions raised by those investigating medicine as a potential career, will serve as an enrichment resource in the instructional programs of the secondary schools of the district.

Mrs. J. C. Griffin, Jr., health career chairman who made the presentation, explained that a number of companion manuals to the film are already in the junior and senior high schools to supplement the film. Both are releases of the American Medical Association.

Mrs. Griffin said that these materials have been placed in the schools to stimulate further interest among pupils in all types of health careers and allied professions which number about 700.

"Part I of the materials is designed to acquaint students with what is involved in becoming a physician. It discusses the various preparatory stepping stones—academic and otherwise—in high school and college, in medical school and in the subsequent postgraduate training of internship and residency programs," Mrs. Griffin emphasized.

Part II describes a variety of career opportunities existing in eight major fields. It covers opportunities available to high school and college graduates, merits of each field, places of employment and prevailing wage scales.



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Dr. Williams Heads Gettysburg Group

Dr. M. Ney Williams, Jackson anesthesiologist, was elected chairman of the Gettysburg Memorial Commission at the organizational meeting in the Old Capitol Museum House of Representatives.

The commission was recently appointed by Gov. John Bell Williams to plan a memorial monument at Gettysburg where Mississippi troops fought July 1, 2 and 3, 1863. Committee members Clarence A. Pierce and Gray Evans were named to go to Gettysburg to select a site for the tribute.

The Department of Interior will have to approve the site selected, size and type of monument to be erected as well as the inscription to be placed thereon.

Gov. Williams commissioned the group to work diligently to have all plans and details of the project completed for presentation to the next regular session of the Legislature.

RMP Sets Up Pulmonary Unit

A pulmonary demonstration unit has been established at University Medical Center "to lead the way to improved care for the state's victims of emphysema, asthma, bronchitis, and other chronic lung disease."

The demonstration center, funded by a $376,000 two-year grant from the Division of Regional Medical Programs, will also serve as teaching base for those who work with pulmonary disease victims, including doctors, nurses, technicians and the patient's family.

The unit plans to work with 10 patients a day. These patients, accepted by referral, will be screened on admission, so a program of intensive treatment and education can be made for their special needs.

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CONTENTS

ORIGINAL PAPERS

Primary Carcinoma of the Lung: Prevention, Diagnosis and Treatment **331** JOHN W. BOWLIN, M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXVI: Traumatic Myositis Ossificans **339** JAMES V. FERGUSON, JR., M.D.

Proceedings of the House of Delegates, 101st Annual Session **341** Annual Publication

EDITORIALS

USA v. CAP: Compromise of a Distressing Saga **357** Antitrust and Labs

The Private Sector, the Inner City, and Medical Care **360** Insurance Industry Response

AMA: Not Even the Appearance of Evil **361** Conflict of Interest

Updated Policy, Enlightened View **361** USCC Views Medicare

The Liberals Go for Family Planning **362** Congress Acts

THIS MONTH

The President Speaking **356** Warranty of Integrity

Medical Organization **367** Health Screening Given State First Graders

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Donors Can Now Give Blood Until Their 66th Birthday

Americans in good health can be blood donors now until their 66th birthday instead of the 60th or 61st as in the past.

A joint announcement of this liberalization of medical standards for blood was made today by the American Association of Blood Banks of Chicago and by the American National Red Cross in Washington, D. C. The two organizations together collect and process 90 per cent of the more than 6,500,000 pints of blood used annually for surgery and therapy in U. S. hospitals.

"This extension of the eligible age limit for blood donors is in recognition of two facts," explained Dr. Frank Coleman of Tampa, Florida, President of the Association. "First, that the need for blood is constantly increasing at a rate of about 12 per cent annually. Second, that, thanks to better medical care, better nutrition and other factors, Americans are living longer and also keeping their health and vigor longer than in the past."

Dr. Tibor J. Greenwalt, Medical Director of the American National Red Cross Blood Program, emphasized that any healthy person can give a pint of blood without worry.

He said, "we have many donors who have given 11, 12 and even 13 gallons of blood without incident. Most of these are eager and able to continue giving. The change will permit them to do so except in jurisdictions where it is contrary to local regulations."

Donors 66 years of age or over, under the new AABB and ARC policies, may continue to give blood if they obtain the written consent of their personal physician on the day of donation.

Donors must be in good health, have normal temperature, pulse and blood pressure, and meet the other requirements for blood donors. Individuals should check with their local community or hospital blood bank or Red Cross blood center relative to their eligibility to give blood.

State laws generally require blood donors to be 21 years old or to have parental consent to give between 18 and 21, but a number of states, including California, Kansas, Washington, New York, Indiana, Oklahoma, Minnesota and Oregon, recently enacted legislation permitting those 18 to 21 to give without parental consent. In some states those of this age who can give blood must be self-supporting and living away from home.

Both organizations have blood clearinghouses.

permitting blood given locally to be credited to patients in other cities and areas with surplus blood to aid those where it is short. Exchanges between the two clearinghouse systems are made possible under a joint interorganizational agreement signed between the AABB and ARC.

Experimental Ambulance Service Gets Underway

Jackson, Laurel and Columbia will pioneer in an experimental helicopter ambulance rescue service this year, according to Meredith Tatum, state director of the Governor's Highway Safety Program.

The project, funded by a $450,000 U. S. department of transportation grant, will provide emergency medical service to persons injured in highway crashes. Developed by Mississippi State University researchers, the demonstration program is one of a series in several states being funded by the Highway Safety Act of 1966.

Testing is designed to provide the department of transportation with statistics for a proposed national helicopter rescue system, including cost effectiveness in rural and industrial areas and minimum requirements for helicopter ambulances, attendants and operators.

The state will get some permanent benefits from the project in the form of emergency communications systems for hospitals with emergency rooms. The project will initially cover 27 counties and eventually reach 40, added Tatum.

Special para-medical attendants will be trained in 72-hour classes at the University of Mississippi Medical Center and will accompany pilots on their rescue missions.

When crashes occur on the highway within the coverage area, either a helicopter medical team or a ground ambulance team will be dispatched to the crash location according to a predetermined plan.

The medical team will provide emergency first aid on arrival at the scene while the injured are being evacuated to the nearest medical facility capable of providing treatment required.

Either the helicopter or ground ambulance team will be in direct radio communication with the hospital prior to arrival to give information on the number of the injured and the types of injury of each person.

The operational period of the experiment will be 6½ months in addition to a 2½-month preparatory period and a 1½-month follow-up period.



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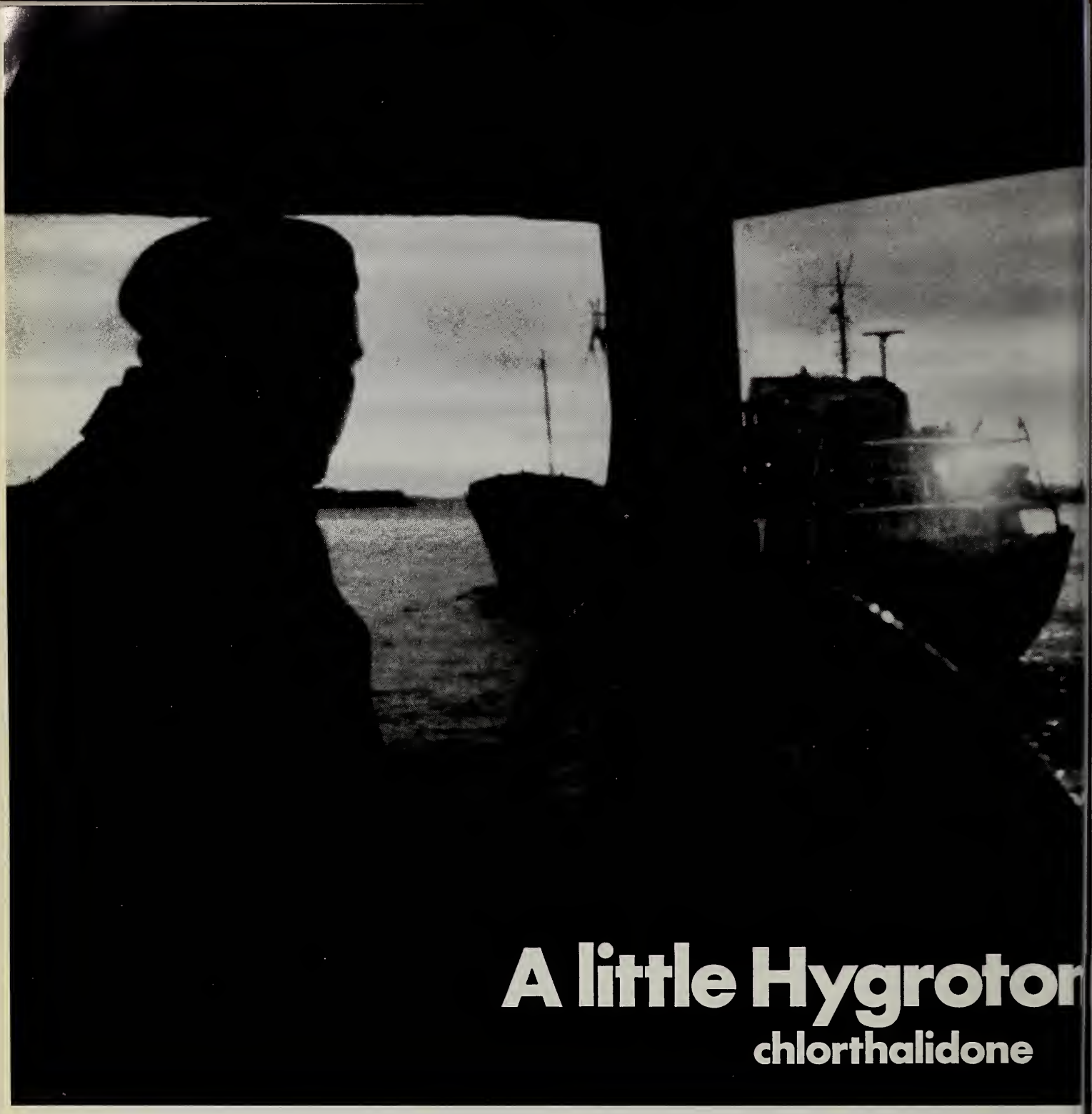
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

August 1969

Dear Doctor:

Governor Williams' endorsement and support of Medicaid gave big boost to measure which has state medical association approval. Most legislators appear to support program with debate centering around who and how much. Except for House Speaker Junkin, leaders in both houses support program.

> Salt-and-pepper issues sprinkled early days of session as the Governor sent up miscellaneous matters. Educational TV and purchase of old Robert E. Lee Hotel building received quick consideration. Without explosive highway program, session could be fairly short.

Network TV is bringing back medicine as prime time entertainment stronger than those eternal house officers, Kildare and Casey. CBS will initiate new dramatic series this fall titled "U.M.C.," meaning, of course, University Medical Center. Background is mythical major training institution, and title is sure to suggest association with Mississippi's UMC.

Mississippi Hospital Association squared off against a state medical association policy at recent Coast convention. MHA adopted a resolution opposing physicians as members of a hospital governing board. MSMA stands for physicians membership. Action was led by hospital administrators who make up majority of MHA house of delegates.

The Internal Revenue Service has singled out for special treatment all physicians who earned $25,000 a year from Medicare and Medicaid. Each will have a special IRS tax audit which was initiated by Social Security Administration. Additionally, Part 1-B carriers will henceforth use physicians' Social Security numbers on all payments.

Quietly - almost unnoticed - Veterans Administration services are being substantially extended, if Congress acts on pending bills. One would authorize unlimited nursing home care to service-connected veterans, while another would presume that any veteran over age 72 is unable to meet any medical care costs.

Sincerely,

Rowland B. Kennedy
Executive Secretary

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DATELINE - MEDICAL AMERICA

Fag Makers Relent With New Compromise

Washington - The tobacco industry, in an adroit manuever before a Congressional committee, has offered to halt all radio and TV cigarette advertising by September 1970 but not without a strong quid pro quo. Fag makers want guarantee of no death warning in printed advertising which would be continued. Action followed announcement of broadcasters that cigarette advertising would be phased out over four years. Previously, FCC apparently lost fight to get smoke off airwaves. Tobacco industry went farther by offering to stop air ads this year with protection against antitrust action. Move is regarded as astute with tobacco fortunes ebbing.

AAP Revises Adoption Policies

Evanston, Ill. - The American Academy of Pediatrics has announced approval of single parent adoptions and a new aspect of the parent-child relationship, permitting the prospective mother to visit and see the child prior to adoption. Statement said that although AAP still prefers two-parent or family adoption, it believes that love and care can be provided by single parent and that age, economic status, and education should not be serious barriers for parent qualification.

Nixon Takes Hard Line On Drug Abuse

Washington - The Nixon administration has taken a hard line on illicit drugs and marijuana with legislation aimed at stopping sources and assisting states in local enforcement. Justice Department responded after soft Supreme Court decision on marijuana.

Transplants May Soon Be Covered By Insurance

New York - The Health Insurance Institute, spokesman for the industry, says that transplant procedures will probably be covered by super major insurance with benefits as high as $100,000 in the near future. While no existing policy is known to cover transplants specifically now, many companies are paying kidney transplants under major contracts. Industry is thinking big, saying that procedures should be covered when medically accepted as being "no longer experimental." Generally, benefits will be available after exhaustion of present major medical or deductibles of about $500.

Care Costs Rank Lower On Inflation Spiral

Washington - Despite blazing publicity continually given to rising medical care costs, it still ranks behind food, shelter, and clothing on the inflation spiral. U.S. Bureau of Labor Statistics says that on a 100 point scale for one year food rose 17.4; mortgage money was up 13.9; clothing zoomed 11.8; and medical care costs rose 8.2, less than half the rate of food. Actually, medical costs increase roughly parallels that of general economy.

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try Norgesic first... 8 of 10 patients probably won't need anything stronger

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Indications: Symptomatic relief of acute mild to moderate pain of musculo-skeletal origin.

Contraindications: Due to the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy, obstructions at the bladder neck, achalasia (megaesophagus), myasthenia gravis or in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering Norgesic to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

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Medical Schools Need Funds

Physicians recently received a letter from Dr. Milford O. Rouse, president of the AMA Education and Research Foundation, urging increased financial support for the nation's medical schools. He warned that unless a solution is found to ease the financial straits of these institutions, several medical schools are in imminent danger of shutting down.

"Our medical schools are feeling the effects of the major cutbacks in federal support. Hardest hit are the older, private medical schools which depend on private funds and endowments for the major portion of their operation expenses," Doctor Rouse said.

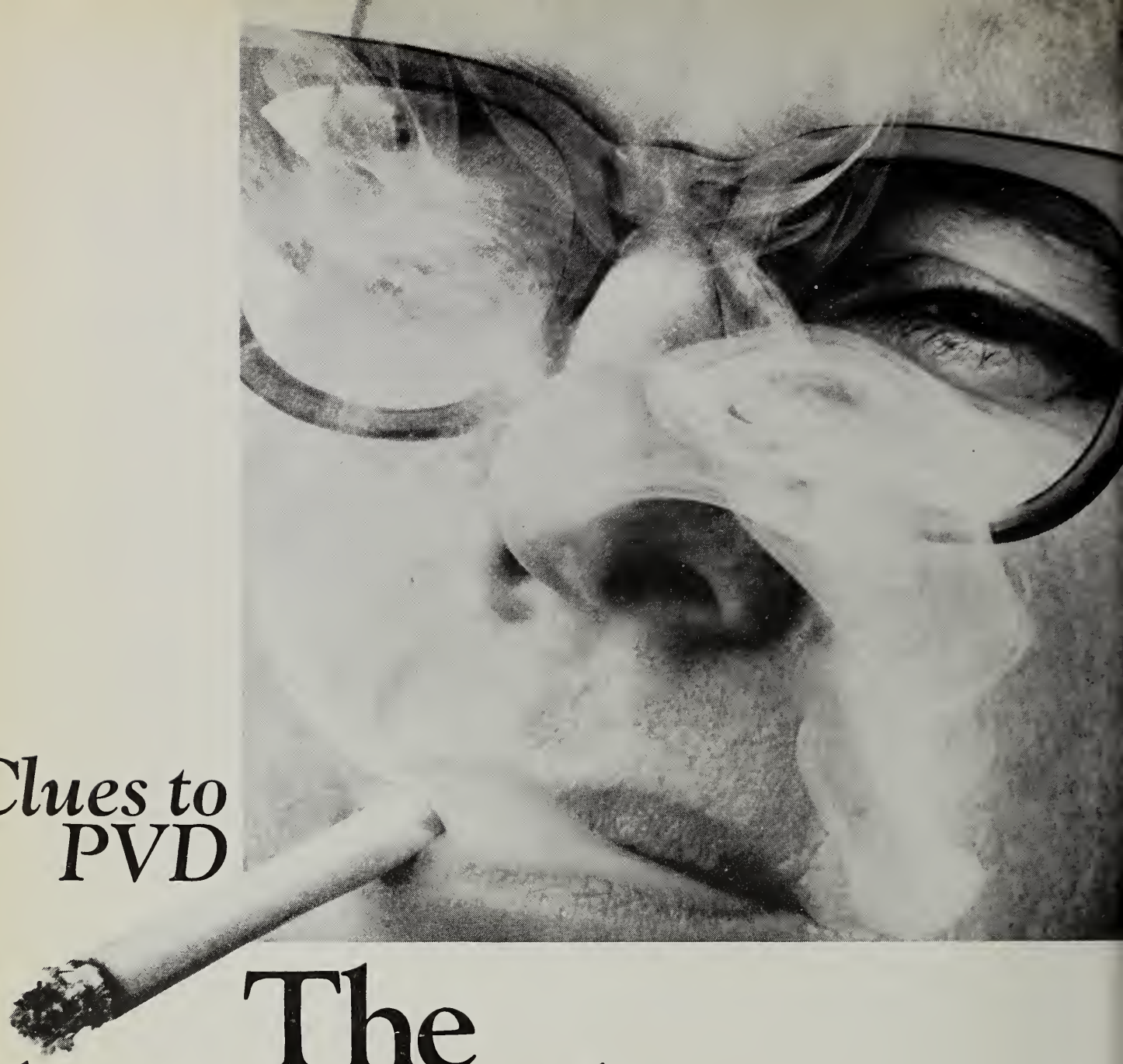
He appealed to each physician to contribute at least $100 so that the AMA-ERF would have a substantial sum to distribute among the needy schools and enough left over to build a nestegg for the future.

A variety of literature explaining the urgent financial requirements of medical schools, plus pledge cards and forms for contributing in behalf of one's anniversary, birthday, or remembrance, are available in quantity from the AMA-ERF, 535 North Dearborn Street, Chicago, Ill. 60610.

To his fellow physicians, Doctor Rouse emphasized the medical profession's inherent responsibility to its own progress and growth. He asked, "Save a school. Send your contribution to the Fund for Medical Schools today. So many futures depend on it. Including yours."

AMA Offers Special Price on Audio News Journal

The American Medical Association's new *Audio News Journal,* introduced this past winter to keep each physician-subscriber up-to-date on the latest developments in all aspects of medicine, now offers a special package price for 12 monthly, 60-minute tapes, plus a choice of two cassette tape recorder-players. One is the battery-operated RCA Firebird for $105, and the other is the RCA Daredevil which plays on both battery and AC outlets, for $115. This special price represents a considerable savings on the cassettes inasmuch as the subscription price for the 12 tapes alone is $72. Orders should be directed to the AMA Circulation and Records Department.



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Miniature BCG Aids Research

The production of a miniature Ballistocardiograph, one million times more sensitive than a human BCG, has been announced by the United States Technical Development Co., Philadelphia, Pa., a Division of United States Banknote Corporation, New York.

This laboratory instrument (patent pending) invented by V. L. Rogallo, a research scientist, and assigned to U. S. T. D. Co., opens new avenues of investigation in biology, physiology, vaccine production and drug research.

A prototype has been used by FDA, Bureau of Toxicological Evaluation, for drug research and U. C. Davis, Department of Poultry Husbandry, for avian embryo research.

Although sufficiently sensitive to monitor the heartbeat of a chick embryo less than 3 days in incubation through hatch without physical harm to the organism, the unit can also measure dynamic functions of small animals unaffected by the complications imposed by usual measurement techniques requiring surgical operation, bearing of restrictive weight, probes, and/or unnatural activity. Changes in heartbeat rate and intensity resulting from temperature changes, external stimuli and growth are readily detected by the instrument. A dual integrator that will amplify not only acceleration but velocity and displacement is also available.

Additional or specific information is available from the Sales Director, Special Products Division, U. S. Technical Development Co., 3620 G Street, Philadelphia, Pa. 19134.

Second Surgery Congress Meets at Montreal

The second Western Hemisphere Congress of the International College of Surgeons will convene at the Queen Elizabeth Hotel, Montreal, Canada on September 1-5, 1969.

The Congress will feature scientific sessions in anesthesiology, coloproctology, general surgery, neurosurgery, obstetrics and gynecology, ophthalmology, orthopaedics, otorhinolaryngology, plastic surgery, thoracic and cardiovascular surgery, and urology.

Special events include the Arnold Jackson Memorial Lecture and luncheon, round table discussion and luncheon, convocation and luncheon and banquet.

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Brochures and information on financial arrangements available

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Sixth Annual New Orleans Pulmonary Course Set

The sixth annual New Orleans course on Pulmonary Function in Health and Disease will be held at the LSU School of Medicine auditorium December 8-11, 1969.

The postgraduate course is presented by the American Thoracic Society, Louisiana Thoracic Society, Louisiana State University School of Medicine, Tulane University School of Medicine and Alton Ochsner Medical Foundation.

Guest faculty include Dr. Reuben Cherniack, professor of medicine, The University of Manitoba, Canada; Dr. Alfred P. Fishman, professor of medicine, University of Pennsylvania Medical School, Philadelphia; Dr. Norman Staub, associate professor of physiology, University of California Medical Center, San Francisco; Dr. William H. Tooley, department of pediatrics, University of California Medical Center, San Francisco; and Dr. John West, professor of medicine, University of California School of Medicine, La Jolla.

Topics to be covered at scientific sessions are mechanics of breathing, clinical spirometry and lung volumes, blood gases and their transport, office pulmonary function testing, ventilation-perfusion relationships, pulmonary gas transfer, physiological principles in the management of respiratory failure, pulmonary function in children, regulation of pulmonary circulation, alveolar hypoventilation, pulmonary edema, interdependence of pulmonary structure and function, pre-operative pulmonary function evaluation.

Panel discussions, demonstrations and case presentations will also be featured. Social highlight of the meeting will be Monday evening at 6:30 p.m. when Barnes Hind Pasna Company hosts a Get-acquainted Cocktail Social at the Royal Orleans Hotel.

Fee for the postgraduate offering is $100 for physicians and Ph.D.'s and $50 for all others. Checks should be made payable to the Louisiana Thoracic Society.

For further information contact Miss Joan Ritchie, course registrar, Suite 407, Louisiana Thoracic Society, 305 Baronne Street, New Orleans, La. 70112. She can be telephoned at (504) 523-3093.

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Average Hospital Costs Published

The Health Insurance Council has announced publication of "Survey of Hospital Charges as of December 1968," an itemized breakdown of hospital expenses throughout the nation.

The book details costs—including x-ray, drug and laboratory—in terms of average hospital charges. It divides the United States into census division, state, and standard metropolitan statistical areas including the nation's 25 largest counties.

The national survey also reports on charges for intensive care and extended care units as well as average daily service charges in both voluntary and proprietary hospitals.

It was prepared by the American Hospital Association for the Council.

To obtain a copy, write to William W. Reinertson, Health Insurance Council, 750 Third Avenue, New York, N. Y. 10017.

Price is ten dollars for the first copy and five dollars for each additional copy.

Tenth Annual CV Symposium Scheduled

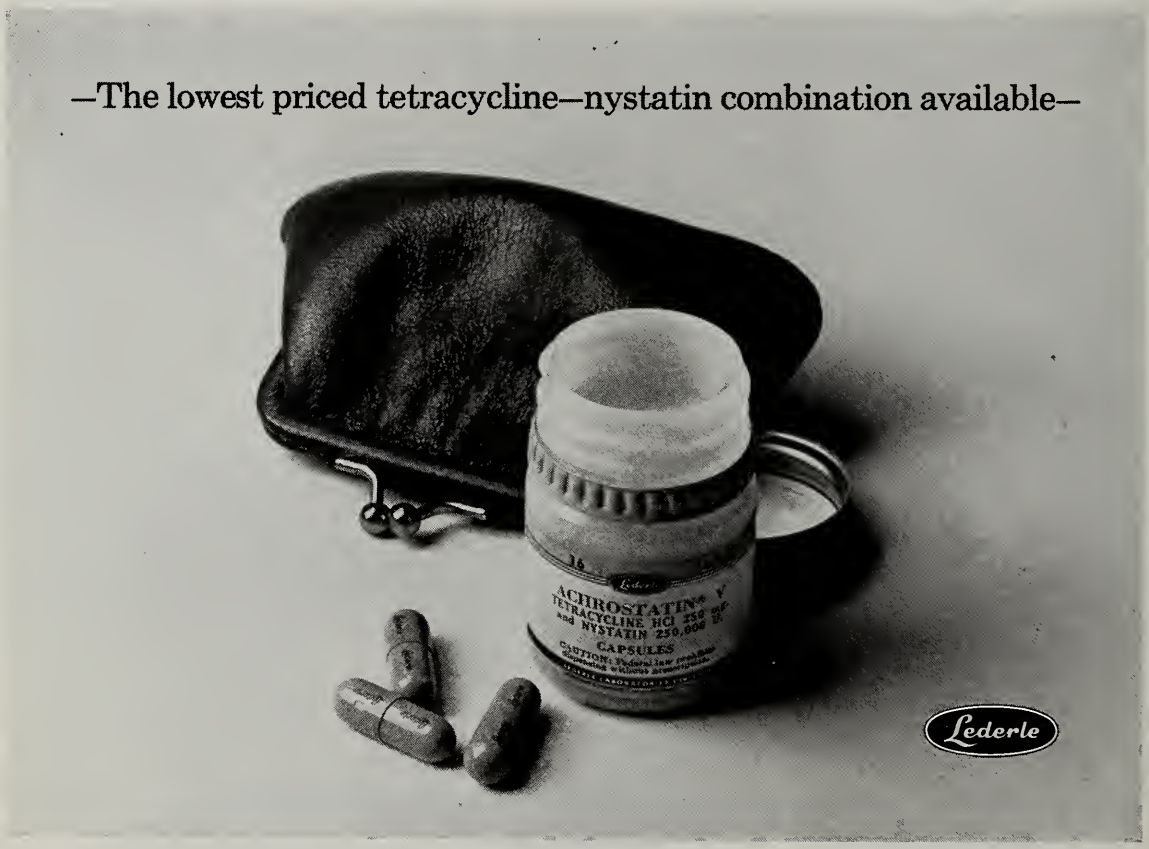
The tenth annual cardiovascular symposium of the Tidewater Heart Association will convene at the Williamsburg Lodge, Williamsburg, Va. Sept. 5-7, 1969.

The conference, jointly presented by the Tidewater Heart Association, the Peninsula Heart Association and the Council on Clinical Cardiology of the American Heart Association, will feature guest lectures, panel discussions, sponsor's exhibits, and question and answer periods.

Guest faculty include: Dr. Denton Cooley, Dr. Arthur M. Vineberg and Dr. David Kritchevsky. The topics to be covered are arrythmias, hypertension, cardiogenic shock, aldosteronism, myoischemia, cardiac revascularization, and cardiac transplantation.

Registration is set for 8:00 a.m. Friday, Sept. 5, 1969 in the Lodge's East Gallery.

The $25 registration fee includes all meetings and tickets for the Friday evening reception and the Saturday evening dinner.



JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
August 1969, Vol. X, No. 8

ORIGINAL PAPERS

Primary Carcinoma of the Lung: Prevention, Diagnosis and Treatment

JOHN W. BOWLIN, M.D.
Tupelo, Mississippi

PRIMARY CARCINOMA of the lung, showing an alarming rise in mortality, accounted for 2.6 per cent of the total United States mortality or for 48,483 deaths in 1965.[1] The prevalence of primary carcinoma of the lung has changed from a rarity deserving of inquisitive study by pathologists, surgeons, and medical students of three or four decades ago to the most common cause of death due to malignant disease in men. In the male age group 50-59 one of three deaths is caused by carcinoma of the lung.

Both experimental studies and clinical observations indicate that primary carcinoma of the lung (epidermoid carcinoma) is caused by smoking. Microscopic studies of the bronchial mucosa in the pack per day smoker will show an absence of cilia, squamous metaplasia and/or carcinoma in situ in 99 per cent. In contrast, these changes are seen in the only 16 per cent of non-smokers.[2] Clinical observations are just as convincing toward indicating a causal relationship of carcinoma of the lung to cigarette smoking. Any thoracic surgeon probably can count on his fingers the number of primary carcinomas of the lung he has seen in male non-smokers. Dr. Oscar Auerbach has said, "A patient who has an epidermoid or undifferentiated carcinoma of the lung is a smoker."[3]

Presented before the Alcorn County Medical Society, Corinth. Miss., Oct. 28, 1968.

The increase in number of deaths caused by primary cancer of the lung is paralleled by the steady rise in total sales of cigarettes. Combined experimental and clinical evidence leaves little doubt that tobacco is a causative factor in carcinoma of the lung. Early diagnosis with surgical resection is the only curative management for this disease which today is the most common malignancy in men.

In lung cancer we find a most precise dose—response relationship to cigarette smoking, regarding the number of cigarettes smoked per day, the degree of inhalation and the number of years the patient has smoked. Data from seven prospective studies has shown a 9-11 fold increase risk of lung cancer among men cigarette smokers as compared to non-smokers.[4] More evidence of the association between cigarette smoking and lung cancer has appeared since the 1964 report by the surgeon general on the hazards of tobacco. The American Medical Association is soon to present findings from its multi-million dollar research program on the relationship between tobacco and health. Although the American Medical Association has branded cigarette smoking

a "serious health hazard," it has not accepted the United States Public Health Service doctrine that there is a causal relationship between cigarettes and lung cancer.

ANTI-SMOKING REGIMEN

Among established smokers and teen-agers there seemingly is an utter disregard for the increasing intensity of antismoking campaigns with the total sale of cigarettes continuing to rise. With a more vigorous physician-patient antismoking campaign, the practitioner of medicine must become more concerned with the prevention of death from bronchogenic carcinoma of the lung. The Doll and Hill[5] study done in England supports the value of stopping smoking, although one may have smoked for many years. In that study, a group of physicians either stopped or decreased smoking by a substantial amount and experienced a 30 per cent decrease in mortality from carcinoma of the lung. In that same period within the general population of England and Wales the amount of smoking had not decreased and the mortality from lung cancer increased by 25 per cent. Such reports as this should serve as ample stimulus for the physician to encourage his patients to stop smoking.



Figure 1. Small tumors located in the hilar region of the lung may be overlooked. The lesion seen here in the left hilar area was asymptomatic and discovered on routine annual film. This lesion proved to be oat cell carcinoma when resected by pneumonectomy.

FACTS ON HAZARD

The informed smoker expects his physician to take an active part in persuading him to stop smoking and expects the physician to have the "numbers" to convince him. The September, 1968, issue of *Diseases of the Chest* is recommended reading in "how to help the patient stop smoking." To stop the smoking hazard in adults and to prevent it in teen-agers has been identified as the most important disease prevention problem now facing the public. It has been estimated that if cigarette smoking were completely stopped, about 15 per cent of the entire cancer problem would be eliminated.

While there is wide variation in the microscopic appearance of bronchogenic carcinomas, occasionally even different cellular patterns being seen in the same tumor, one of three cellular patterns is seen throughout or will be predominant. Epidermoid or squamous cell carcinoma accounts for 50 to 75 per cent of all primary carcinomas of the lung. Cigarette smoking is closely correlated with this cellular type. These tumors tend to originate in the intermediate and large bronchi. Squamous cell tumors are generally regarded as slower growing than other cellular patterns, being more likely to spread to the hilar lymph nodes at a later stage in growth. Squamous cell tumors offer the best chance of cure to the patient. This tumor usually presents on chest x-ray as a density in the mid-lung field. Cavitation and/or adjacent pneumonia are more common than with other cellular types.

COMMON CELLULAR TYPE

Anaplastic or undifferentiated carcinoma is the second most common cellular type. These tumors grow more rapidly, hematogenous spread is frequent and five-year survival is rare. Anaplastic tumors, particularly oat cell type, usually arise in the large bronchi and often the abnormal density on x-ray will be seen as a prominence of the pulmonary hilum or may blend in to the mediastinal shadow (Figure 1).

Adenocarcinoma is the third category of cellular patterns. These tumors arise in peripheral bronchi, vary greatly in their microscopic picture and spread primarily by the blood stream. Prognosis is intermediate.

All bronchogenic carcinomas tend to metastasize early, thus accounting for the high mortality rate. Blood born metastases tend to occur earlier than do lymphatic metastases, thus the less chance of a localized tumor and the higher mortality seen in the undifferentiated tumors and adenocarcinoma. Brain, liver, bone and adrenal are the most common sites of distant spread with bronchogenic carcinoma of the lung.

SYMPTOMATOLOGY

It has often been said that there are no symptoms of early lung cancer. All too frequently the presenting symptoms and physical findings indicate non-resectable intrathoracic extension of the tumor or distant metastatic spread. The mildest symptoms may be most important and those which enable the physician to suspect the diagnosis at an early stage. For the most part, the presenting symptoms, signs, and radiographic findings are determined by the location of the neoplasm. Pain in the ulnar distribution of the hand may be caused by a Pancoast[6] tumor of the lung apex, and the shadow of this tumor radiographically may be suggestive of nothing more than apical pleural thickening (Figure 2). However, special films will demonstrate bony erosion in not too advanced lesions. Subtle wheezing or asthmatic-like symptoms in the patient with good pulmonary reserve may be caused by incomplete blockage of the main stem bronchus (Figure 3). Gynecomastia may appear when the neoplasm involves the anterior thoracic pleura or may appear secondary to involvement of the adrenal gland with metastasis. The astute physician may diagnose an early pulmonary neoplasm after his patient complains of weakness in the extremities typical of the neuromyopathic symptoms; or the unfortunate patient may exhibit convulsions indicative of cerebral metastatic disease. These symptoms and signs represent the variety of the unusual picture the patient may present, but they should be mentioned and remembered because the unusual and subtle symptoms, if recognized, may lead to a five-year survival.

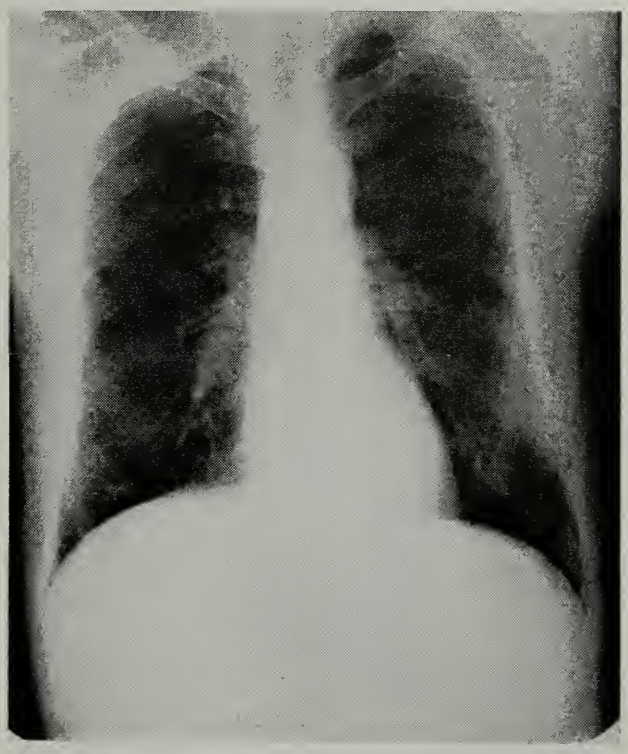


Figure 2. Pancoast tumors often cause bony destruction as shown in this chest x-ray. Following the recommended management of Paulson and Shaw,[17] this patient had irradiation therapy of 3000 rads tumor dose with subsequent en bloc resection of ribs, tumor and right upper lobe and additional postoperative irradiation.



Figure 3. This patient's only complaint was "asthma" in spite of a large segment of obstructive atelectasis and a large necrotic tumor extending from the pericardium to the lateral chest wall. Curative resection was feasible by intrapericardial ligation of the pulmonary artery and pulmonary vein combined with extrapleural radical pneumonectomy. Postoperative irradiation was administered because tumor extended to resected pleura and tumor was present in resected mediastinal lymph nodes.

The true symptomatic triad of primary carcinoma of the lung is cough, hemoptysis and chest pain. With careful history most patients will relate that cough was their first symptom. This "smoker's cough" or a change in cough will have been present for four to six months in the usual patient before he decides to consult a physician and perhaps only then because a more prominent symptom appears. It is unfortunate that hemoptysis is not more frequent for this is one symptom for which the patient will seek medical attention. The initial bout of blood-streaked sputum occurs when the neoplasm first erodes through the bronchial mucosa. Hemoptysis in amounts profuse enough to be classified as pulmonary hemorrhage rarely occurs with bronchogenic carcinoma, even in the late stages of the tumor. Chest pain may be an actual tightness in the chest caused by mediastinal shift with atelectasis distal to a tumor, but more often the pain is of pleuritic type either from pneumonia associated with the tumor or from direct extension of the tumor to involve the parietal pleura.

PNEUMONIA

Cases of tumor with unresolved pneumonia, or better termed "obstructive pneumonia," are being recognized earlier now and appropriate diagnostic studies started sooner. Pneumonia or an infiltrate not completely resolved after four to six weeks of therapy or a follow-up chest film showing a residual shadow should at that time be investigated as possibly being caused by a neoplasm. "Bronchial obstructive pneumonia" caused by tumor characteristically has the septic course of the atelectatic, segmental pneumonitis with fever and perhaps chills. However, little sputum is produced and often atypical organisms are cultured from the sputum. The superior segment of the lower lobes and the anterior segment of the upper lobes are notorious locations for such "bronchial obstructive pneumonias" caused by bronchial neoplasms (Figure 4).

A significant number of patients with bronchogenic carcinoma of the lung will present with only signs and symptoms of distant metastases. Neurological symptoms are common since spread to the brain and spread to the vertebra or long bones is frequent. These symptoms are not to be confused with those of so-called "carcinomatous neuromyopathies," consisting of peripheral neuropathy, myositis and neuromuscular disorders. Symptoms consist of weakness, paresthesias, pain and sensory loss associated with decrease in deep tendon reflexes. These symptoms most often present in the extremities and occasionally advance to a state of ataxia and loss of muscle mass. Such neurological symptoms are reported to be present in 12 to 15 per cent of the cases of bronchogenic carcinoma of the lung.

NEUROLOGICAL SYMPTOMS

The incidence of neuromyopathic symptoms is not related to the size of the primary pulmonary lesion nor to the presence of metastatic disease. These neurological symptoms may precede the obvious appearance of the tumor on chest roentgenogram and often will abate following surgical resection of the pulmonary neoplasm.[7] Other extrathoracic manifestations of the pulmonary neoplasm are pulmonary osteoarthropathy, hyperparathyroidism-like syndrome with elevated serum calcium, Cushinoid syndrome, gynecomastia, hyponatremia and excessive secretion of antidiuretic hormone.

One of two radiologic changes is apparent in the presence of bronchogenic carcinoma. One is due to the actual growth of the tumor and presents as a density in contrast to uninvolved adjacent pulmonary tissue. The second, a later development, is the presence of atelectasis or pneumonia due to bronchial invasion and obstruction by the tumor. Often both shadows will be present.

In the case of incomplete bronchial obstruction by tumor, the involved segment may be over aerated and appear emphysematous on chest x-ray. In the early stages of atelectasis the lung may have a decreased volume with minimal shift of the mediastinum and decreased ventilation of the involved area, but without infiltration.

IMPORTANCE OF X-RAY

The need for a lateral chest x-ray cannot be overemphasized. A lesion may be noted on lateral film to be anterior or posterior in location, while on the anterior projection it was interpreted as a prominence of the hilar broncho-vascular shadow. A lesion superimposed with the heart shadow may not be detected on the posterior-anterior projection. Tomograms can be of invaluable aid in confirming the presence of a homogenous tumor density within a secondary shadow of pneumonia. Tomograms can also be of considerable benefit in the demonstration of mediastinal or chest wall involvement by tumor. The patient with asthma-like symptoms caused by a

bronchial neoplasm partially obstructing a main stem bronchus may have his chest x-ray interpreted as showing equivocal hilar prominence. Such tumors causing unilateral prominence of the pulmonary hilum are the most frequently overlooked on chest x-ray (Figure 1) and often require study by tomograms for confirmation.

Tomograms are helpful in determining the presence or absence of calcium within a pulmonary lesion. Calcium may be demonstrated as flaky in appearance or there may be a central core of calcification as often seen in benign granulomas. However, carcinoma can be excluded only if calcium is present in concentric rings. Review of any previous chest x-rays is invaluable in the evaluation of suspicious pulmonary lesions. An homogenous abnormal density on chest x-ray is bronchogenic carcinoma until proven otherwise, and films must be present over a three-four year period demonstrating no change before the need for thoracotomy can be excluded.

DIAGNOSTIC TECHNIQUE

In the diagnostic work-up of patients suspected of having pulmonary neoplasms, bronchoscopy is almost always performed. The occasional exception is the patient with the peripherally located asymptomatic lesion. Approximately 35-40 per cent of bronchial carcinomas can be seen at the time of bronchoscopy. Bronchoscopic biopsy of the lesion will confirm the suspected diagnosis and eliminate cutting into the tumor at the time of thoracotomy to establish a histologic diagnosis. Lobectomy may be carried out for a suspected carcinoma without confirmation with biopsy. However, a microscopic diagnosis of carcinoma is necessary before performing a pneumonectomy.

RESPONSE TO PROCEDURE

The patient's response to bronchoscopy performed under topical anesthesia gives the surgeon some index of the patient's pulmonary function reserve. Heavy smokers with chronic bronchitis and chronic pulmonary disease receive a therapeutic benefit from bronchoscopy and bronchial lavage with saline, bronchodilators and mucolytic agents. Atelectatic pulmonary segments may clear if enough tumor can be removed at bronchoscopy to open up the obstructed bronchus. These benefits of bronchoscopy can substantially improve the respiratory status of the patient and thus decrease the risk of thoracotomy and resection. By the same token all patients in whom resection is anticipated are encouraged to stop smoking.

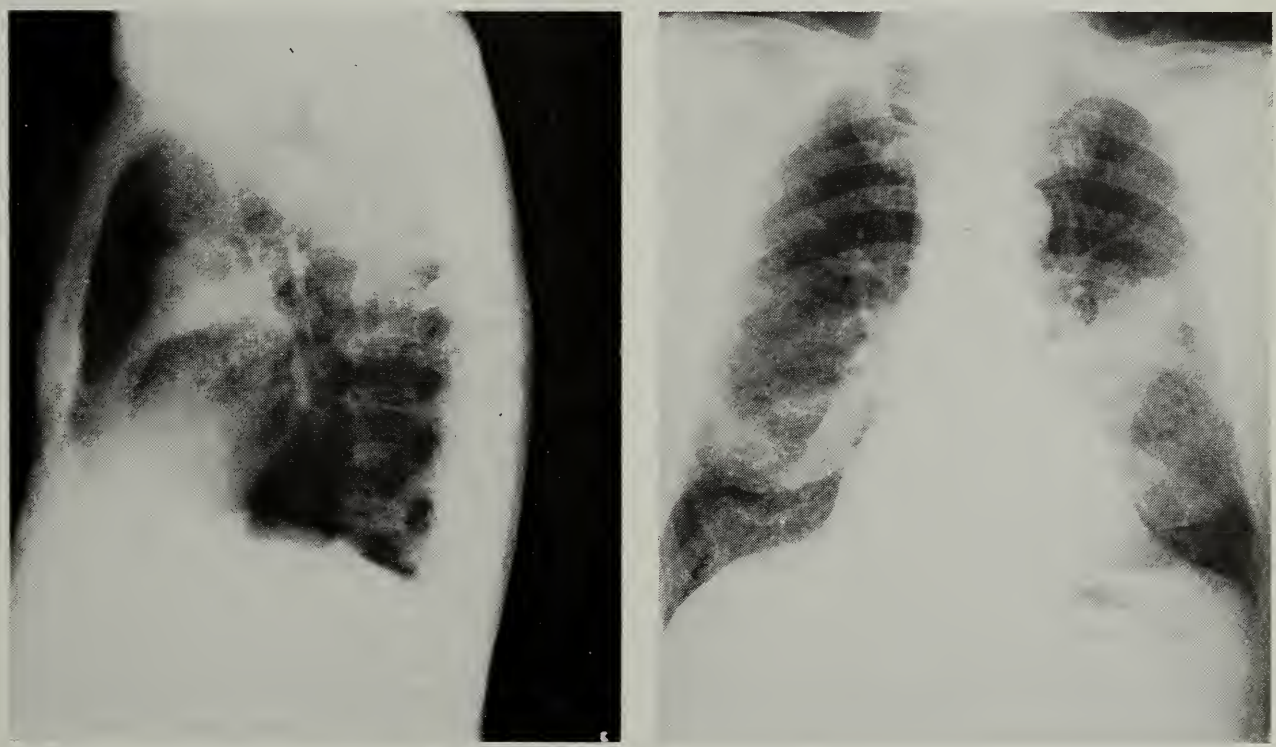


Figure 4. This chest x-ray of a 74-year-old male well illustrates obstructive pneumonia associated with a bronchial neoplasm. This squamous cell carcinoma of the anterior segment of the left upper lobe was resected by left upper lobectomy.

Biopsy of the scalene group of cervical lymph nodes was introduced by Daniels[8] in 1949 as a diagnostic procedure in respiratory diseases. This procedure, done under local anesthesia, is now more or less routinely performed in suspected or proven cases of carcinoma of the lung in order to detect extra-thoracic lymphatic spread of the tumor. With complete removal of all lymph nodes in the scalene area, particularly those located at the junction of the jugular and subclavian veins, approximately 12-15 per cent of specimens will show metastatic involvement. Metastatic nodes in the scalene area are rarely palpable on routine physical examination of the patient because of their deep location in the thoracic outlet. Mediastinal and/or paratracheal nodal involvement with tumor is likely if the scalene nodes are involved with tumor. However, not infrequently we find that a pulmonary lesion is non-resectable because of mediastinal involvement with tumor when the scalene node biopsy has been negative for tumor involvement.

MEDIASTINOSCOPY

Carlens,[9] in 1959, introduced mediastinoscopy as a means of detecting this paratracheal and mediastinal extension of tumor. This procedure is now being done sporadically in the United States. Reports of patients having had mediastinoscopy show that there are approximately ⅓ fewer thoracotomies for non-resectable lesions in those patients having undergone mediastinoscopy in combination with bilateral scalene node biopsies. We feel this procedure has particular merit in the patient who is a poor risk for thoracotomy and in those patients with paramediastinal or mediastinal lesions. Positive biopsies from the scalene nodes or from mediastinoscopy should be considered a contraindication to thoracotomy.

There are other studies and procedures available for use in detecting the presence of metastatic bronchogenic carcinoma or for showing evidence of intrathoracic extension of the neoplasm beyond the limits of resection. Pulmonary angiography demonstrating obstruction of the pulmonary artery by tumor may be indicative of a non-resectable lesion. We have encountered several large epidermoid tumors involving the great vessels (pulmonary artery and vein) and/or pericardium in which a curative resection was feasible with the technical use of intrapericardial suture ligation of the pulmonary artery and the left atrium,[10] Figure 3. Unless findings dictate special studies, our further evaluation has consisted of tests to detect possible spread to the liver and adrenals. Serum alkaline phosphatase determination is used as a screening study for liver spread and if elevated is followed by liver scan. Adrenal function tests are employed for preoperative assessment of adrenal function. Metastatic carcinoma may involve the adrenals with resultant hypoadrenalism, or adrenal hyperfunction may occur with bronchogenic carcinoma, though not necessarily indicating that metastatic disease exists.

TUMOR RESECTION

Surgery is the only definitive curative treatment for localized primary carcinoma of the lung. In evaluating patients suspected of having bronchogenic carcinoma, attention should not only be on establishing the diagnosis but also directed toward the feasibility of performing a curative resection of the tumor. In Paulson's[11] experience only 15 per cent of patients had localized bronchogenic carcinoma at the time of diagnosis, 30 per cent had evidence of regional spread and the remaining 55 per cent had demonstrable distant metastases. With thorough evaluation in the selection of patients for thoracotomy combined with improved techniques of both standardized and extended methods of pulmonary resection, the thoracic surgeon should strive for a 75 to 80 per cent resectability rate without increased morbidity or mortality.

SURGEON'S ATTITUDE

An aggressive and bold attitude is required of the thoracic surgeon in the treatment of lung cancer, but efforts should be made to avoid thoracotomy for non-resectable lesions. It should be emphasized that operability and resectability are widely different terms. In a great number of cases the histologic diagnosis will remain in question until the time of thoracotomy. Such is often the case with lesions located in the mid and peripheral lung field in which there is no evidence of local or distant spread.

The first successful long-term survival following surgical resection for carcinoma of the lung was performed by pneumonectomy in 1933.[12] The patient outlived the surgeon who succumbed to the same disease 24 years later. For two-three decades pneumonectomy was considered the only

type of resection applicable for surgical extirpation of primary carcinoma of the lung. However, lobectomy is now known to offer just as good a result in the peripherally located tumor and is of definite value over pneumonectomy in the patient with borderline pulmonary reserve or when resection of the chest wall is necessary for curative resection of the neoplasm.

Radical mediastinal node dissection, which the author feels is often indicated in the resection of an epidermoid type tumor, can be combined with lobectomy as with pneumonectomy, though technically is more applicable to upper lobectomy than lower lobectomy.

Oat cell carcinomas carry the worst prognosis, with five-year survivals rare. There exists some controversy among surgeons as to whether oat cell tumors should be resected. It is the author's opinion that resection of a localized completely resectable lesion should not be contraindicated on the basis of cellular pattern particularly when the diagnosis is made at thoractomy and by frozen section examination.

PREOP RADIATION

By the use of preoperative irradiation, Pancoast tumors of the apical portions of the lung, tumors involving the chest wall, and some few tumors involving the mediastinum may be converted from non-resectable to resectable. Application of surgery to post-irradiated tumors involving mediastinal structures as vena cava and esophagus probably result in a higher operative mortality without an increase in the five-year survival rate.[13]

The presence of distant metastatic disease and local extension of the neoplasm beyond the confines of resection classify a neoplasm inoperable. These contraindications to surgery are generally well known; however, a few deserve comment. Tumor cells present in pleural fluid is a contraindication to operation; however, a bloody pleural effusion may be caused by pneumonitis distal to an obstructive neoplasm and when the tissue diagnosis of carcinoma is lacking, a bloody pleural effusion is not considered a contraindication to thoractomy. To say that the phrenic nerve is involved with tumor, paradoxical motion of the diaphragm must be seen at fluoroscopy. This is a contraindication to thoracotomy if the tumor is involving the phrenic nerve cephalad to the pulmonary artery. Paralysis of the phrenic nerve caused by lesions located at or caudad to the pulmonary artery does not contraindicate thoracotomy for the entire portion of the nerve with underlying pericardium can be resected. A history of recent hoarseness which is unrelenting and proven by direct laryngoscopy to be caused by recurrent nerve involvement is a contraindication to thoracotomy. Occasionally it is necessary to sacrifice an uninvolved recurrent nerve in order to remove all neoplastic nodes; however, when the nerve is involved by tumor causing hoarseness it is rare that a curative resection can be performed.

INOPERABLE CASES

Superior vena cava syndrome is a contraindication to surgery and is best treated by nitrogen mustard followed by irradiation therapy with the additional use of adrenal steroids to minimize tissue edema.

A second category of patients with pulmonary neoplasm will be considered inoperable on the basis of inadequate pulmonary or cardiac reserve. This is determined on the basis of physical examination, the patient's exercise tolerance and the results of cardio-pulmonary function studies. Determination of the maximum breathing capacity and timed vital capacity are necessary in borderline evaluations, though in the uncooperative or uninformed patient the tolerance to exercise may be more valid in deciding the patient's risk for surgery. A maximum breathing capacity of less than 40 liters per minute is generally considered a contraindication to pneumonectomy. Cardiopulmonary function studies may show false evidence of insufficiency if large segments of atelectasis are present resulting in the shunting of unoxgenated blood through the pulmonary circulation. In such cases the patient's cardio-pulmonary status would actually be improved with resection of the tumor and distal atelectatic lung. All patients over 60 years of age are digitalized prior to thoracotomy because of the high incidence (30) per cent) of cardiac arrythmias following radical pulmonary resection.

PALLIATIVE TREATMENT

As palliative treatment and as an adjunct to surgical resection, irradiation therapy has no doubt achieved a sound place in the treatment of bronchogenic carcinoma. Sound clinical judgment should be used in the selection of patients for irradiation therapy before or following resection so as not to magnify the chance of surgical complications or result in acute pulmonary prob-

lems during the recovery period. It would appear that irradiation therapy has most to offer in the conversion of non-resectable lesions to resectable lesions, as in the preoperative irradiation of Pancoast tumors and tumors involving the chest wall. Irradiation treatment will frequently lessen the pain accompanying osseous metastases. Irradiation therapy may be administered to a tumor obstructing a bronchus in the hopes of tumor shrinkage and relief of atelectasis and pneumonitis. Alleviation of the suffering from vena cava syndrome is an indication for irradiation therapy. With less definite indications for irradiation therapy the selection of patients and mode of treatment varies considerably.[15] In general the favorable reports in the palliative treatment of unresected tumors has been a slight (three to four months) increase in longevity and generally the cause of death is the same as in non-irradiated patients.[14]

The chemotherapeutic agents have little to offer in the palliative treatment of bronchogenic carcinoma of the lung. Nitrogen mustard is the only agent worthy of mention. The failure to improve survival by the addition of an alkalating chemotherapeutic agent (nitrogen mustard) at the time of surgery has been clearly demonstrated.[16] Nitrogen mustard may occasionally be of benefit in the control of rapidly recurring malignant pleural effusions. The patient's general condition and general response to nitrogen mustard often will be the deciding factor about its use. ★★★

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COURTEOUS CROOK

The world's most polite bandit waved a pistol at the bank's customers and announced pleasantly: "Now, ladies and gentlemen, all those in favor of leaving these premises alive will kindly hold up their hands."

Radiologic Seminar LXXXVI: Traumatic Myositis Ossificans

JAMES V. FERGUSON, JR., M.D.
Greenwood, Mississippi

TRAUMATIC MYOSITIS OSSIFICANS may follow a single severe injury or repeated slight injuries. In the former the principal cause is laceration of the periosteum and displacement of the torn periosteum with its bone forming cells away from the shaft. In the case of repeated injury the lesions are thought to be due to a true metaplasia of local connective tissue cells into osteoblasts. Interstitial hemorrhage is thought to play an important causative role.

Localized traumatic myositis ossificans is usually observed in young males following trauma and is often located around the knee or anterior aspect of the arm. Calcification occurs after the development of osteoid and finally well oriented bone is formed. Calcification may appear within three to four weeks following trauma. Some ossifications completely disappear or regress due to osteoclastic absorption.

The case presented is that of a 15-year-old football player, a lineman, who used his right shoulder for blocking. He first complained of pain in the lower right arm about the first week in September, 1968. One week later films of the right elbow region were normal. He continued to play football and the soreness became more severe. He also developed considerable swelling of the lower right arm. Four weeks following the initial onset of symptoms additional films of the right humerus and right elbow were obtained. These revealed a marked amount of calcification and/or ossification just anterior to the middle one-third of the humerus. This was noted to be fairly dense and somewhat in layers apparently



Figure 1. Lateral radiograph of the right humerus. Note soft tissue calcification and/or ossification anterior to the middle one-third of the right humerus.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Greenwood LeFlore Hospital.

conforming to the muscle bundles. Other scattered calcifications were noted to extend distally to the crease of the elbow (Figure 1). ★★★

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PRENATAL INFLUENCE

I was just establishing a small-town practice when I delivered a young matron of a child with six digits on each hand and foot. Speculation about the phenomenon was soon rife among the townspeople, with explanations ranging from prenatal marking to prenatal diet.

Perhaps the pattest explanation of all was vouchsafed by a mother who announced positively, "That's what comes of having a young, inexperienced doctor!"

—Charles R. Harris, M.D.

Proceedings of the House of Delegates

101st Annual Session
May 12-15, 1969
Biloxi, Mississippi

THE 66TH ANNUAL SESSION of the House of Delegates was convened during the 101st Annual Session of the Mississippi State Medical Association, in pursuance to lawful notice given, on May 12, 1969, in the Fountain Terrace of the Hotel Buena Vista at Biloxi, Mississippi, at 9:06 o'clock in the morning, by Dr. Joseph B. Rogers, the President. The invocation was spoken by the Rev. Mr. Olin Beall, pastor of the Church of the Redeemer, Biloxi.

After extending greetings, Dr. Rogers presented the Vice Speaker, Dr. John B. Howell, Jr., of Canton and the Speaker, Dr. William E. Lotterhos of Jackson who assumed the chair. Dr. Walter H. Simmons, Chairman of the Reference Committee on Credentials, reported the presence of a quorum of registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

ANNOUNCEMENT OF REFERENCE COMMITTEES

Reports of Officers and Board of Trustees
- Stanley A. Hill, Corinth, Chairman
- Arthur E. Brown, Columbus
- C. R. Jenkins, Laurel
- George H. Martin, Vicksburg
- James R. Cavett, Jackson

Medical Practices
- Leo J. Scanlon, Jr., Natchez, Chairman
- John G. Egger, Drew
- John R. Shell, Vicksburg
- Eldon L. Bolton, Biloxi
- James L. Royals, Jackson

Miscellaneous Business
- Jack A. Atkinson, Brookhaven, Chairman
- Paul B. Brumby, Lexington
- John F. Lucas, Sr., Greenwood
- Eddie E. Bramlitt, New Albany
- Thomas W. Wesson, Tupelo

Credentials
- Walter H. Simmons, Jackson, Chairman
- Victor E. Landry, Lucedale
- Prentiss F. Keyes, DeKalb

Rules and Order of Business
- Frank M. Davis, Corinth, Chairman
- Angus M. McBryde, Sumrall
- Loutrelle Stribling, Carthage

APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

George H. Martin, Vicksburg, Chairman
Jack A. Stokes, Pontotoc
Charles R. Jenkins, Laurel

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

To assist the Speaker and Vice Speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business. Under the By-Laws, the business of the House must be conducted according to *Robert's Rules of Order, Revised,* and the Speaker and Vice Speaker should prescribe the order of business as set out in the By-Laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

Reference Committees. The purpose of reference committees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions presented should be referred to the appropriate reference committee by the chair immediately after their presentation, the only exception being those which are of such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the Constitution and/or By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

ADOPTION OF TRANSACTIONS

On motion by Dr. Stanley A. Hill of Corinth, second by Dr. H. C. Ricks, Sr., of Jackson, the Transactions of the 65th Annual Session of the House of Delegates, 100th Annual Session of the association, May 13-16, 1968, Jackson, published in Volume IX, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1968, were adopted.

REMARKS OF THE SPEAKER

Dr. William E. Lotterhos: Your Speaker and Vice Speaker welcome you to the 101st Annual Session of the Mississippi State Medical Association and the 66th annual session of our House of Delegates.

Your Speaker is serving you for his second term and your Vice Speaker for his first term, having been appointed to replace the vacancy created by the elevation of Dr. James L. Royals to the position of President-elect during the session last year. Even though it must be quite a letdown from having served as Chairman of the Board of Trustees for so many years, I am sure that your Vice Speaker cherishes his job and is well versed in parliamentary procedure, and he is a welcome asset in this position.

He and I feel that the parliamentary proceedings of this House of Delegates should conform with the usual acceptable rules. In fairness to all participants, we do not wish to prohibit anyone from making pertinent comments, or by suppressing in any manner relevant debate, but we desire that all members be completely informed on the items under discussion, and we trust that no one will cast a vote until he is completely satisfied within his own mind that the action he is about to take will be, first, for the best interest of the patient that is served by medicine and, second, for the best interest of medicine.

The actions that are usually taken by any body such as this are to approve, disapprove, or modify a question. If you are in doubt, it may be appropriate to refer for further study or amend in such a manner that it will be more acceptable to you. A tabling motion should never be used to cut off debate or to kill an issue. If this should arise, it is the Speaker and Vice Speaker's opinion that a two-thirds majority would be necessary under such circumstances.

During the past year your Speaker and Vice Speaker have been invited to attend all Board meetings. All of these were attended by your Vice Speaker and most of them by your Speaker. On one occasion, the Speaker was ill from "Hong-Kong flu" and the Board was kind enough to take cognizance of this fact and even sent him a get well telegram which read as follows: "By a vote of 4 to 3 with 2 members abstaining, the Board of Trustees wishes you a speedy recovery." Thank goodness for the abstainers!

As you probably know, we attend these meetings as your representatives. We are ex officio members by custom, and I would like to recommend that there be a constitution and by-laws change to include the Speaker and Vice Speaker as members of the Board of Trustees, non-voting ex officios. This gives the mechanics of setting up a channel for your Speaker and Vice Speaker to see that all requests directed to the Board by this House of Delegates are carried out; and on the other hand, all activities and actions of the Board are reported and explained to the House of Delegates. Your Speaker and Vice Speaker would be in a better position to see that these are accomplished.

The Vice Speaker, the Executive Secretary, and I attended a Southeastern Speakers of Medical Organizations conference in Atlanta, Georgia, which I personally feel was very worthwhile, and would like to recommend that the association continue to sponsor the Speaker and Vice Speaker's attendance at these annual meetings. The next

one is proposed for February, 1970, to be held in New Orleans. At this meeting, the question again arose as to who appoints the reference committees. Of the ten states attending, eight stated that the Speaker and Vice Speaker were given this duty, and the other two states (Mississippi included) gave this power to the President.

Now, I am not trying to build up power for the Speaker or Vice Speaker but I am recommending that you reconsider the same issue that was proposed last year, and that is, that our constitution and by-laws be changed to allow your Speaker and Vice Speaker to make selection and appointment of the reference committees. This should not offend any president and really there is no political gain to be expected when one is called upon to serve the association in this capacity. For the sake of a smoother operating organization, the Speaker and Vice Speaker should have this prerogative.

This year, by permission of the Board of Trustees, a manual explaining the powers and duties of reference committees has been written and distributed to all members of the reference committees and general officers. We hope that this will facilitate the functions of those committees and it will surely make us feel more comfortable in what we are doing.

Now, as a prerogative of the Chair, I am appointing as the Parliamentarian for this session of the House of Delegates the Vice Speaker, and when he is presiding, I am requesting that he call upon the Speaker as his Parliamentarian. We may not take each other's advice but at least we will have someone to turn to if any of you guys try to put us in hot water.

In conclusion, I would like to remind you that we wish for this session of your House of Delegates that each one of you will have the feeling that you may express your sentiments, that we here in the Chair are your friends and that it is our desire to see that the democratic process is fully carried out. Let us be about our business in a friendly, informed, democratic atmosphere.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee commends Dr. William E. Lotterhos of Jackson, the Speaker of our House of Delegates, and his able associate, Dr. John B. Howell, Jr., of Canton, the Vice Speaker, for their fair and impartial conduct of the deliberations of this House of Delegates. We thank Dr. Lotterhos and Dr. Howell for having a breakfast meeting of all reference committee members and for Dr. Lotterhos' having drafted a manual for guidance of the reference committees. We recommend that similar training be repeated at the 102nd annual session of the association.

We approve the remarks of the Speaker and recommend that the portion referred to your Reference Committee be adopted by this House of Delegates.

The report of the Reference Committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The Speaker of the House of Delegates made two recommendations which would involve amendments to the By-Laws. He recommended that he and the Vice Speaker be non-voting *ex officio* members of the Board of Trustees. Under the Constitution and By-Laws, the Board has no *ex officio* members but by custom and usage, the President, President-elect, Secretary-Treasurer, Speaker, Vice Speaker and Delegates to the American Medical Association regularly sit with the Board in all deliberations and receive all materials which are furnished to the Board. Your council believes that any amendment to the By-Laws providing for *ex officio* status for the Speaker and Vice Speaker would serve no useful purpose and we recommend that the proposal be not adopted.

The Speaker of the House of Delegates has recommended that Section 4 Chapter VII of the By-Laws be amended to provide for his appointing reference committees. The appointive powers of the association are vested in the President. Your council believes that this is a wholesome balance of legislative and executive power and we believe that the proposal of the Speaker should not be adopted.

The report of the council, acting as a reference committee, was adopted.

PRESENTATION OF DISTINGUISHED GUESTS

The Speaker presented the following distinguished guests:

Dr. John M. Chenault, Decatur, Alabama, member of the Board of Trustees, American Medical Association.

Mr. Thomas Windham and Mr. Thomas Crowson, student delegates, University of Mississippi School of Medicine.

Mr. Whalen M. Strobhar, Chicago, Illinois, Assistant Director, Division of Public Affairs, American Medical Association.

Mr. Leon Swatzell, Memphis, Tennessee, Field Representative, American Medical Association.

ADDRESS OF THE PRESIDENT

The Speaker declared the House of Delegates in open session, and the President, Dr. Joseph B. Rogers, delivered his address. The address has been published separately in Volume X, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1969.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We commend and applaud Dr. Joseph B. Rogers, our 1968-69 president, on his splendid address to the House of Delegates. Your reference committee was particularly interested in his proposal with respect to the individual responsibility plan which is designed to assure the integrity of the physician-patient relationship. Your reference committee approves this concept.

We congratulate and commend Dr. Rogers on his service to our association and wish him well as he takes his place in the ranks of our past presidents.

The chairman of the reference committee moved adoption of the report. Dr. Dewey H. Lane, Jr., of Pascagoula amended the motion by moving that a model plan or letter be prepared and disseminated to the membership, using examples of other states and making it clear that it is for optional use. Dr. Lane's motion to amend was seconded by Dr. R. J. Moorhead of Yazoo City.

In discussion, Dr. Rogers stated that the proposal is purely voluntary with individual physicians. He said that it was not rigid and might be used as the individual physician sees fit.

The chair put the motion of the reference committee as amended which was adopted.

GIFT OF THE PAST PRESIDENTS

The Speaker recognized Dr. Lawrence W. Long of Jackson, a Past President of the association. Dr. Long addressed the House of Delegates, stating that the 17 living Past Presidents had taken as a project the design of a flag for the association. He and Dr. H. C. Ricks, Sr., of Jackson have acted as a committee in behalf of all Past Presidents in the project.

The association flag displays the emblem of the organization centered in a field of white with the words, "Mississippi State Medical Association," surrounding the heraldic device.

In making the presentation to Dr. Rogers, the President, and Dr. C. D. Taylor, Jr., Chairman of the Board of Trustees, Dr. Long asked the Past Presidents present to stand with him at the rostrum. Responding were Drs. S. Lamar Bailey of Kosciusko, Everett Crawford of Tylertown, G. Swink Hicks of Natchez, Stanley A. Hill of Corinth, Howard A. Nelson of Greenwood, B. B. O'Mara of Biloxi, H. C. Ricks, Sr., of Jackson, A. Street of Vicksburg, James Grant Thompson of Jackson, and James T. Thompson of Moss Point.

Dr. Long then presented the association flag and companion flags of the United States of America and of the State of Mississippi. Each is carried on a mahogany staff, capped with an appropriate standard. The flags are trimmed in gold fringe and decorated with gold cord and tassels.

The gifts of the Past Presidents were accepted for the association with expressions of appreciation by Dr. Rogers and Dr. Taylor who said that they would be placed permanently in the association's building.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

100th Annual Session. At the 100th Annual Session in 1968, your Council on Constitution and By-Laws considered four amendments to the By-Laws. Two were adopted by the House of Delegates and two failed to pass.

Section 4(c), Chapter I, was amended to permit the association to furnish the Journal without charge to members of the association who are exempt from dues by reason of service in the Armed Forces other than as regular officers.

Section 2, Chapter VI, was amended to provide for a substantially altered nominating process.

101st Annual Session. There are presently no pending amendments to the Constitution or By-Laws. Your council will hold itself in readiness to consider any proposed amendments which may be brought before the House of Delegates at the 101st Annual Session.

The report of the council was received for information.

REPORT OF THE JUDICIAL COUNCIL

Constitutional Responsibilities. Your Judicial Council is one of eight elected councils of the association and one of the three which reports directly to the House of Delegates. Under the provisions of Section 4, Chapter IX, By-Laws of the association, the council is charged with exercise of the judicial powers of the association and interpretation and application of the *Principles of Medical Ethics of the American Medical Association.* The rulings of the council are subject to the

will of the House of Delegates, and its judicial decisions may be appealed to the Judicial Council of the American Medical Association.

In 1960, this House of Delegates approved the council's proposals as to procedural authorities with reference to controversies or actions involving members of the association. These rules of procedure were reviewed during the 1968-69 association year, and your council recommends no change.

Council Activities. The council is glad to report that there were no matters at controversy involving members or component medical societies of the association before it during the 1968-69 association year. The council, in an effort to be of service to the association, addressed itself exclusively to matters of medical ethics.

The council was fortunate in having the opportunity to meet with Edwin J. Holman, LL.B., of Chicago, secretary of the Judicial Council of the American Medical Association. Mr. Holman came to Mississippi on our invitation and met with the council on Oct. 30, 1968. His advice and counsel have been most valuable in our deliberations.

Our state medical association executive office has secured for each member of the council a complete set of Opinions of the Judicial Council of AMA through 1968, and we are regularly receiving copies of new opinions as they are issued.

Medical Ethics. The Judicial Council has issued opinions in a number of areas of medical ethics and submits these opinions to the House of Delegates for the guidance of the membership:

(a) *Telephone Directory Listings.* It is preferable for a physician's name to be followed by the designation "M.D." in telephone directories rather than to be preceded by the designation "Dr." The latter can be confusing, since it is a designation claimed by those who are not physicians. In classified sections of telephone directories, physicians' names should be listed alphabetically, and the size and face of the type should be uniform. The component medical society should establish such guides in this connection as are deemed appropriate and assure service to the public through locally acceptable telephone listings.

(b) *Compulsory Assessments.* Compulsory assessments upon members of a hospital medical staff, that is, assessments which if not paid might cause the physician to lose staff membership, are not in the best traditions of ethical practice. It is not proper to condition medical staff membership on compulsory assessments for any purpose.

(c) *Transplantation of Human Tissue.* When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests. Transplantation of body organs should be undertaken only by physicians who possess special medical training, study, and laboratory experience and practice and in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

(d) *Drugs and Devices.* Ownership of shares in a pharmaceutical manufacturing company by a physician is not unethical when the physician cannot and does not exercise control over the company or permit it to influence his choice of drugs. It is unethical for a physician to own shares in a drug repackaging house.

(e) *Treatment of Obesity.* Management of obesity is a difficult medical problem requiring the utmost in cooperation between patient and physician with full consideration for the individual patient's needs medically. The use of so-called "rainbow pills" in the treatment of obesity and the so-called shotgun prescribing of cardiac glycosides, thyroid hormones, diuretics, anorexiants, barbiturates, amphetamines, and laxatives for the overweight is to be condemned. Use of cardiac glycosides and thyroid extracts in so-called "rainbow pill" regimens are to be especially condemned.

(f) *Laboratory Services.* Laboratories operated in the name of a physician who spends a small portion of his time in its direction and those operated by nonphysicians raise frequent questions. Some are good, and some are poor. Often, the appeal of these laboratories, especially those out-of-state, is economic. A physician's responsibility to his patient is to provide quality services, including those personally performed and those delegated to consultants. Medical judgment based on inferior laboratory work is likewise inferior. A physician is responsible for his diagnosis and treatment, and caution should be exercised with the understanding that difficult situations could result in instances of professional liability with some out-of-state laboratories.

(f) *Bank Credit Cards.* Since bank credit cards are substitutes for cash or checks, it is not unethical for a physician to participate in a bank card program. The component medical society should satisfy itself as to the financial and professional integrity of the plan and assure that service charges to physicians are reasonable. The individual physician may not, because of his participation, increase his fee, and he may not encourage patients to use the cards. His position is that he accept the card as a convenience to patients who desire to use it. Plaques, signs, and other devices indicating participation in a bank

card plan in a physician's office shall be kept to a discreet and dignified minimum. Such signs outside the physician's office are unacceptable. Use of bank card in connection with payment of larger fees which might normally be paid to the physicians in installments is not to be encouraged. The patient who elects to use a bank credit card for payment of medical fees should be encouraged to pay on the first billing by the bank card service so as to avoid interest charges.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

The Judicial Council has rendered a number of opinions with respect to medical ethics for the guidance of members of the association. We approve the work of the council and commend it on its substantial accomplishments of the year.

In putting the motion to adopt the report, the chair called attention to pages 11 and 12 of the *Handbook of the House of Delegates,* the report of the Judicial Council. The report of the reference committee was adopted.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted seven meetings since the 100th Annual Session when this report is considered by the House of Delegates. The Board met in May, twice in August, and in December of 1968. In 1969, the Board met in February and has meetings scheduled in April and May. Altogether, the seven meetings included nine meeting days, usually exclusive of travel.

This annual report includes actions on matters referred by the House of Delegates and those items relating to management and policy functions which are among the Board's responsibilities.

Referrals from the House of Delegates. Matters referred by the House of Delegates at the 100th Annual Session and actions by the House requiring consideration by the Board of Trustees include:

(a) *Amendment to the By-Laws, Journal.* On recommendation by the Board, the House of Delegates amended Section 4(c), Chapter I, to permit furnishing the JOURNAL without charge to members of the association who are exempt from dues by reason of service in the Armed Forces of the United States other than as a member of the regular establishment. The Board has implemented this amendment, authorizing the Executive Secretary to furnish such JOURNAL subscriptions.

(b) *Amendment to the By-Laws, Nominations.* Section 2, Chapter VI, was amended to alter the nominating process substantially, selecting the Nominating Committee one year in advance and requiring the committee to conduct formal meetings at least three months prior to the annual session at which elections are to be held and to publish the slate of nominees at least one month prior to the annual session. The committee members are also required to consult the membership in their respective districts and societies and prospective nominees as to their willingness and ability to serve, if elected. This amendment has been implemented, and the slate of nominees is being published in the April 1969 issue of the JOURNAL and in the Handbook of the House of Delegates.

(c) *New Component Medical Society.* The House of Delegates approved the Board's action on a petition from the physicians of Jackson County for chartering of a new component medical society. On Nov. 6, 1968, formal ceremonies were conducted at Biloxi during the annual meeting of the Coast Counties Medical Society during which the charter was presented to the Singing River Medical Society to become effective Jan. 1, 1969. The President, assisted by the Chairman of the Board, made the presentation, and the Board of Trustees welcomes the new society as the 18th component of the association.

(d) *Fee Review.* The House of Delegates requested that the Board of Trustees offer "such services as may be made available to component medical societies in organizing and establishing fee review committees." In implementing this action, the Board made guides available for organization and operation of fee review committees, and the President communicated with each society requesting local implementation. In addition, the President addressed a number of societies on fee review activities, and additional mailings were made to the societies in this connection. The Board emphasizes the importance of fee review and again encourages each society to maintain an active, working committee to assure that this function remains within medical organization.

(e) *Resolution No. 2.* The House adopted Resolution No. 2, subject: Office of County Coroner, introduced by the Homochitto Valley Medical Society, which states that the association affirm its belief that coroners should be licensed doctors

of medicine and that the association seek appropriate legislation to accomplish this objective. Implementation of the resolution consisted of active support of H.B. 1110 in the 1968 Regular Session of the Legislature which was finally enacted on July 9, 1968.

(f) *Resolution No. 3.* Adoption of this resolution reaffirmed the association's endorsement of the Health Insurance Council uniform claim form and encouraged component medical societies of the association to endorse use of the form in submission of health insurance claims. The action also asked that local societies establish liaison with representatives of the health insurance industry to assure understanding of the form's use and application and that appropriate publicity be afforded the action in the JOURNAL. The Board has implemented these actions, and the association continues to furnish members pads of the HIC uniform claim forms at cost. The Mississippi Health Insurance Council has given the association its pledge of cooperation, and virtually all major carriers are accepting the claim form. Since adoption of the resolution, the Mississippi Hospital Association, noting the action of our House of Delegates, adopted a similar resolution as the form applies to hospitals.

(g) *Resolution No. 5.* This resolution urges repeal of the 1966 amendments to the Public Health Laws providing for an optometric member of the State Board of Health. In recommending adoption of the resolution, the reference committee at the 100th Annual Session stated that "we stress in this regard that it will take the same type grassroots support by our association to repeal this law as provided by the association (Mississippi Optometric Association) which got the law passed in 1966." Because of other critical legislation relating to optometry and related fields in the 1968 Regular Session, the late date of the action at the 100th Annual Session, and the fact that a new State Health Officer was being appointed, action legislatively was not practical or possible. The Board has consulted the State Board of Health in this connection, and the matter is still pending actively.

(h) *Resolution No. 6.* Adoption of this resolution carried the mandate that the association "urge its component medical societies and each of its members to support such a statewide (tetanus) education and immunization program." Implementation was highly successful, with several societies and local medical communities sponsoring tetanus immunization programs. In concert with the Mississippi Chapter, American College of Surgeons, a major article in this connection was published in the JOURNAL, and editorial support was also given the program. Additionally, the views of the Committee on Occupational Health on immunization against tetanus, previously made a matter of policy, were again publicized.

Official Travel. On recommendation by the Council on Budget and Finance, the Board of Trustees has drawn and promulgated "Guidelines for Authorization, Performance, and Reimbursement of Official Travel in Behalf of the Mississippi State Medical Association." The guides provide for (1) determination and approval for official representation as to necessity and value to the association, (2) selection of representatives, except in instances where other means of selection prevail, i.e., AMA Delegates as representatives at AMA conventions, (3) formal reimbursement policies, and (4) uniform expense vouchers requiring full documentation. In most instances, the Board reviews requests for travel in advance of the trip. All who ordinarily perform official travel have been furnished copies of the guides, and councils and committees desiring to send representatives on official travel are now submitting such requests to the Board of Trustees.

Insurance Programs. The association sponsors three major insurance programs for the membership, consisting of a wide range of plans by the Continental Companies which are administered by Thomas Yates and Co. of Jackson, a professional liability insurance program underwritten by the St. Paul Companies, and a Blue Cross hospital contract.

(a) *Continental Programs.* These plans include accident and health, income replacement, catastrophic hospital expense, life and 65 sickness and accident, various Medicare supplements, accidental death and dismemberment, and group life insurance. Experience has proved satisfactory in all but one plan, the catastrophic hospital expense. With highly adverse experience over the past two years, the company has found it necessary to revise the rate structure upward.

(b) *St. Paul Program.* The crisis in professional liability insurance nationally underscores the desirability of an association-managed program such as has been conducted with the St. Paul Companies since 1961. With professional liability insurance premium rates now at record highs, i.e., $925 for 5/15 surgical coverage in California, the Board of Trustees has re-emphasized its close and continuing supervision of this vital service. The Mississippi rate is the lowest in the nation, and the Board believes that the claims review service available to the membership has been an important factor in this respect. The Board emphasizes the importance of sufficient professional lia-

bility insurance coverage, suggesting that each member consider carefully umbrella coverage in addition to his regular contract.

(c) *Blue Cross Group.* The association's Blue Cross hospital group was upgraded to type 122X contract from the former type 71X contract, thereby increasing the daily room allowance to $20 from $12 and increasing the number of days per confinement covered to 100 from 90. The upgrading resulted in net increases in monthly dues (premiums) of $1.88 single, $4.66 two party, and $5.49 family. A separate supplemental report relating to nonduplication of Medicare benefits is being submitted to the House of Delegates.

The Board of Trustees reviews each of these insurance programs in detail, requiring full data as to income, earned premium, type and extent of benefit payments, participation, incurred loss, reserves, and actuarial information from the carriers. Regular liaison is also conducted in behalf of the Board on a continuing basis by the Executive Secretary.

Appointments. Under the provisions of Section 1, Chapter VII, By-Laws of the association, the appointive powers are vested in the President. During the 1968-69 association year, President Rogers made the following appointments, each of which has the endorsement of the Board of Trustees:

(a) *Vice Speaker.* After his election to the office of President-elect at the 100th Annual Session, Dr. James L. Royals of Jackson expressed the wish that he not continue in a dual officer role, having been elected Vice Speaker in 1967. The President and Board accepted Dr. Royals' wish, and President Rogers appointed Dr. John B. Howell, Jr., of Canton Vice Speaker to serve the unexpired term until 1970.

(b) *Council on Medical Education.* Dr. R. Mayo Flynt of Meridian resigned as a member of the Council on Medical Education, and President Rogers appointed Dr. Frederick E. Tatum of Hattiesburg to serve the unexpired term until 1970.

(c) *MPAC.* Vacancies on the Board of Directors of the Mississippi Medical Political Action Committee were filled as follows: District 2, Dr. Eddie E. Bramlitt of New Albany and District 6, Dr. E. E. Robinson, Jr., of Meridian. Each term is for one year.

(d) *Nominating Committee.* One death and one resignation required appointments to the Nominating Committee which became a continuing body under amendments to the By-Laws at the 100th Annual Session. Dr. John G. Egger of Drew was appointed District 1 member, succeeding the late Dr. E. LeRoy Wilkins of Clarksdale, and Dr. James T. Thompson of Moss Point was named District 9 member, succeeding Dr. B. B. O'Mara of Biloxi who resigned for reasons of health. Dr. Thompson also succeeded Dr. O'Mara as chairman.

(e) *Council on Constitution and By-Laws.* President Rogers appointed Dr. William T. Wilkins of Clarksdale to succeed his brother, the late Dr. E. LeRoy Wilkins, as a member of the Council on Constitution and By-Laws, term to 1969.

Nominations. As required by law, the House of Delegates selected five nominees for one vacancy on the Board of Trustees of Mental Institutions. The nominees are Drs. J. A. K. Birchett of Vicksburg, Eldon L. Bolton of Biloxi, C. P. Crenshaw of Collins, Martin E. Hinman of Vicksburg, and the incumbent, Victor E. Landry of Lucedale. These physicians were formally nominated to Governor John Bell Williams immediately following their selection at the annual session. There were no vacancies to fill on the Mississippi State Board of Health.

Organization of the Board. Two new members of the Board were welcomed for the 1968-69 association year, bringing to a total five new Trustees from 1967 to 1968. Dr. William O. Barnett of Jackson succeeded Dr. John B. Howell, Jr., of Canton as District 5 Trustee, and Dr. Guy T. Vise of Meridian succeeded Dr. Lamar Arrington of the same city as District 6 Trustee.

The President, President-elect, Secretary-Treasurer, Speaker, Vice Speaker, and the two AMA Delegates sit with the Board in all meetings. Officers of the Board of Trustees during 1968-69 are Drs. C. D. Taylor, Jr., of Pass Christian, Chairman; J. T. Davis of Corinth, Vice Chairman; and Mal S. Riddell, Jr., of Winona, Secretary.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

The Board of Trustees in its annual report furnishes the House of Delegates information on matters referred to it by the last annual session and on matters of routine management. The reading of this report makes it quite obvious that the Board is substantially engaged in our behalf and we express our appreciation to the Board for the conduct of this work. We approve the annual report of the Board of Trustees and recommend its adoption.

Before putting the motion of the reference committee to adopt the report, the chair called attention to the annual report of the Board of Trustees in the *Handbook.* The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "A" OF THE BOARD OF TRUSTEES

Amendment of Society Charter. The membership of the Homochitto Valley Medical Society, acting under its own Constitution and By-Laws as well as those of the state medical association, has acted formally to seek amendment of its charter, redesignating the organization as the Adams County Medical Society. The membership feels that the new designation is a more appropriate identification of the society.

A formal petition to this effect, submitted under the provisions of Section 1, Chapter XII, By-Laws of the association, has been reviewed and approved by the Board of Trustees. In the formal action and submission of the petition, the officers and members of this component medical society have properly fulfilled all requirements prescribed by the Constitution and By-Laws.

Accordingly, the Board of Trustees approves the amendment to the charter redesignating the organization as the Adams County Medical Society and recommends concurrence by the House of Delegates. The society remains assigned geographically to District 8, and the amendment to the charter should be effective upon approval by the House of Delegates.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

The Homochitto Valley Medical Society, under the Constitution and By-Laws of the State Medical Association, has submitted a proper and legal petition to change the name of the society to the Adams County Medical Society. This change of name will more appropriately reflect the true makeup of the society, and we note that the membership has complied with all requirements with respect to the charter. The Board of Trustees, as required under the By-Laws, has reviewed and approved the petition. We therefore recommend that the House of Delegates authorize an amendment to the charter of this society re-designating it the Adams County Medical Society from and after the adoption of this recommendation.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "B" OF THE BOARD OF TRUSTEES

Background. For some years, the association has taken the general position that the fragmented health programs for the indigent in Mississippi should be critically reviewed with a view toward elimination of duplication and overlap, and this was one of the bases in adoption of the policy of support for Title XIX, Medicaid. During the summer of 1968, Governor Williams created a Division of Comprehensive Health Planning as a part of his office, assigning to this agency the tasks of comprehensive health planning as envisioned in Public Laws 89-749 and 90-174. Dr. Alton B. Cobb of Jackson was appointed director.

> Under the provisions of Senate Concurrent Resolution 129, enacted during the 1968 Regular Session of the Legislature, the Governor appointed a broadly representative Public Health Advisory Committee which is charged with consideration of a Title XIX program. There is good medical representation on the committee, and the executive committee of the group consists of five members, three of whom are legislators and two of whom are physicians, Drs. Joseph B. Rogers and Everett Crawford.

One of the first projects of the new division was to propose that the Mississippi State Medical Association make a major study on information systems for comprehensive health planning. The Board of Trustees reviewed the proposal and agreed on the merit and desirability of the project. Recognizing that an information system is vital to arriving at valid decisions as to demonstrable health needs, the Board concluded the contract which provided for reimbursement of costs incurred in making the study. The Study Task Force was appointed from among members of the executive staff by the Board and included two research assistants who were employed temporarily during the course of the research phases of the study for about eight months.

Advisory Committee. To advance recommendations, direct the course of the research, and evaluate findings and conclusions, the Board of Trustees appointed an advisory committee consisting of association leadership and members representing the seven sections of the Scientific Assembly:

C. D. Taylor, Jr., Pass Christian, Chairman
Representing General Practice

Joseph B. Rogers, Oxford
Representing Ophthalmology and Otolaryngology

James L. Royals, Jackson
Representing Obstetrics and Gynecology

G. Swink Hicks, Natchez
Representing Preventive Medicine by reason of membership on the State Board of Health

Temple Ainsworth, Jackson
Representing Surgery
Howard H. Nichols, Jackson
Representing Pediatrics
G. Spencer Barnes, Columbus
Representing Medicine

Study Report. The study was concluded in March and was the most extensive single research project yet undertaken by our association. It is, in effect, a blueprint for comprehensive health planning. The 300-page document will be available to the House of Delegates, subject to printing production schedules. The Board of Trustees feels that the working partnership of the association and the Office of the Governor has been productive and that the association has been able to make a contribution in this overall program.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received Supplemental Report B of the Board of Trustees on the Information Systems Study for Comprehensive Health Planning. We are aware that this is the largest single research project ever undertaken by the association and we join with the Board in expressing our belief that the working partnership between the practicing profession and the State of Mississippi is a wholesome contribution to the important work of comprehensive health planning as visualized in Public Law 89-749 and Public Law 90-174. We approve this report and commend the Board on having performed this study.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "C" OF THE BOARD OF TRUSTEES

Background. For more than 15 years, the association has sponsored a Blue Cross hospital service contract for members and their immediate families. This contract, of course, covers only hospital costs and contains no Blue Shield benefits. The last dues (premium) change was in 1965, and as of December 31, 1968, the group had 212 contracts which included single (physician only), two party, and family benefits.

Proposal and Action. The old contract, Type 71X provided for 90 days per hospital confinement, $12 room allowance, and comprehensive ancillary services. The plan proposed upgrading the group to more realistic levels in a Type 122X contract which provides 100 days per hospital confinement, $20 per day room allowance, and comprehensive ancillary services. The Board approved the proposal. A comparison of rates follows:

No. Covered	*71X*	*122X*
Single	$ 6.03	$ 7.91
Two party	15.12	19.78
Family	17.77	23.26

Nonduplication. The Mississippi Hospital and Medical Service has asked the association to sign a nonduplication agreement which would, in the wording of the agreement, "prevent any payment of benefits, as to claims incurred either heretofore or hereafter, under subscriber contracts of this group that would constitute a duplication of benefits allowed under Medicare as provided. . . . " Each group has the option of setting aside the endorsement or agreement, subject to experience rating by the plan for "duplicating" payments.

The Board of Trustees, recognizing that this matter has been the subject of previous discussion with reference to contract benefits and Medicare carve-out, voted to submit the matter to the House of Delegates.

The plan has been formally notified of this action prior to the 101st Annual Session.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee approves the action of the Board of Trustees in upgrading the coverage of members of the association under the Blue Cross Hospital Service Contract. We believe also that the nonduplication agreement should be signed so as to avoid a rate increase in the future, thereby agreeing to a carve-out of benefits which would be provided participants who are eligible under Public Law 89-97, Parts 1-A and 1-B of Medicare. We recommend that the House concur in this action.

The chairman of the reference committee moved adoption of the report. Dr. Mal S. Riddell, Jr., of Winona made a substitute motion that all benefits due the 15 subscribers involved in the Medicare carve-out be paid by the plan prior to the association's signing a nonduplication agreement, second by Dr. G. Swink Hicks of Natchez. There was brief discussion by Dr. S. S. Kety of Picayune and Dr. R. J. Moorhead of Yazoo City.

Dr. Lawrence W. Long of Jackson moved that the substitute motion be amended by referring the matter of the nonduplication agreement back to the Board of Trustees for further study, second by Dr. James T. Thompson of Moss Point. The amendment was discussed briefly by Dr. Walter H. Simmons of Jackson and Dr. Charles M.

Moore of Philadelphia. Whereupon, the chair put the substitute motion, as amended, which was adopted, thereby disposing of the main motion of the reference committee.

In a summary discussion offering information to the House of Delegates, President Rogers said that adoption of the Riddell substitute motion means that the plan should pay the members amounts due them and that the matter of nonduplication has been referred to the Board of Trustees.

SUPPLEMENTAL REPORT "D" OF THE BOARD OF TRUSTEES

Requirement of Hospital. During the 1968-69 association year, it was reported to the Board of Trustees that a Mississippi hospital had instituted rules requiring that a physician report the amount of professional liability insurance he carried as a condition precedent to staff membership and exercise of staff privileges. The Board felt that this rule constituted an unwarranted invasion of a physician's personal prerogatives and directed that legal research as to the propriety of the practice be conducted.

General Aspects. Any membership organization discharging a quasi-official function and whose members benefit in pursuance of their profession or vocation by reason of affiliation therewith is bound by law with reference to its by-laws and rules. It may adopt no by-law or rule which, in the opinion of the courts, is arbitrary, capricious, immoral, unlawful, or contrary to the public interest. A public hospital may not arbitrarily exclude a physician from practice privileges. Further, by-laws must be uniformly and equally enforced upon all members.

The force of statute is generally necessary to cause any individual to prove *ante facto* financial responsibility, as in the case of liability arising out of an automobile accident or requiring an employer to establish responsibility under workmen's compensation. These are clear examples of lawfull "financial responsibility" requirements. By contrast, civil liability is usually determined by court decision in assessment of damages arising out of a tort. Until such judgment is made, the liability does not actually exist, and there is no basis for requiring demonstration of ability to satisfy such undetermined judgment.

The variously determined competency of a physician to hold hospital staff membership is concerned only with his professional and personal fitness to enjoy the privilege, and staff membership is the result of many determinations including his source of medical training, fulfillment of postgraduate requirements (for licensure in a majority of states, although not in Mississippi), a license to practice, and the finding of his peers and the hospital trustees that he is professionally and morally fit to hold staff privileges.

In some instances, medical society membership is a requirement, although this has been held to be restrictive by the courts and has resulted in litigation against hospitals and medical societies in which the applicant-physician has often prevailed. The Mississippi State Medical Association believes that membership in official medical organizations—the component society, state association, and AMA—should not be a precondition for hospital staff membership.

Special Consideration. The legal literature cites a case in point on mandatory disclosure of insurance to hospitals. A California hospital instituted such a requirement, making it mandatory that staff members hold $100,000/$300,000 in professional liability insurance (and so report this to the hospital management) or deposit not less than $300,000 in cash with the hospital as a precondition to staff membership.

A surgeon whose application had not been acted upon by the hospital and who had made no such disclosure sued. He prevailed in trial court and was sustained in the appellate court.

The court held these four key points:

(1) A hospital may not establish rules for a doctor's admission to staff membership other than rules authorized by statute and is thereby limited to matters relating to the physician's competency, his character, and his professional ethics.

(2) The requirement for professional liability insurance or a $300,000 cash deposit as a prerequisite to staff membership is not permissible under the general police powers.

(3) The hospital's board of trustees is not a constitutional legislative body and is without authority to extend any existing statutory requirement.

(4) By requiring professional liability insurance as a precondition to staff membership, the hospital unlawfully delegated to insurers a determination as to what physicians might use its facilities.

Policy Recommendations. The Board of Trustees, recognizing that the association has the obligation and duty to seek the proper interests and rights of its members, recommends adoption of the following policy on mandatory insurance disclosure to hospitals.

> There is a well-established constitutional principle that the power to determine who shall have the right to engage in a lawful

enterprise shall not be delegated to a private body unless the body is accompanied by adequate safeguards which afford the individual protection against arbitrary or self-motivated action. This principle and specific ruling of the courts apply in prohibiting a hospital's requiring disclosure of professional liability insurance or a cash deposit in lieu thereof as a precondition to staff membership.

Physicians are advised that such a requirement constitutes unwarranted and unlawful invasion of prerogatives and rights and that such disclosure might void or otherwise impair the protection which was purchased in insurance, according to the terms of the contract.

The Board of Trustees further recommends that the policy be communicated to the Mississippi Hospital Association, to the Mississippi Association of Hospital Governing Boards, and to the secretaries of the component medical societies of the association.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee concurs in the recommendation of your Board of Trustees that physicians be advised that any requirement by any hospital as to disclosure of professional liability coverage is an unwarranted invasion of the individual physician's prerogatives. We recommend adoption of the Board's proposed policy which would advise physicians that such disclosure is not only unwarranted but might also impair the benefits of the coverage which has been purchased according to terms of the contract. We recommend that this policy be adopted.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "E" OF THE BOARD OF TRUSTEES

Prior Actions. During the 1967-68 year, the Council on Medical Education, in partnership with the Regional Medical Program of the University Medical Center, performed a major study on postgraduate medical education in Mississippi. The study report, "Profile of Attainment—Measure of Need," findings, and recommendations were submitted to and approved by the House of Delegates at the 100th Annual Session. The council, a constitutional body responsible to the Board of Trustees, has proceeded to implement these actions during the 1968-69 association year. Progress reports have been submitted to the Board on three occasions during the year and the work of the council has had the full support and endorsement of the Board of Trustees.

UMC Program. In the study, it was reported that AMA had instituted a formal accreditation of postgraduate or continuing medical education programs in major training centers. On July 12, 1968, AMA accreditation was conferred upon the University Medical Center's program. It was one of the first 20 formal accreditations in the nation.

This assures that the institution will periodically evaluate its program, that there will be consultations and advice on the curriculum, that physicians will be assured of receiving quality instruction, and that inadequate programs will be removed from the educational scene.

The UMC Regional Medical Program has appointed a Subcommittee on Continuing Education, and the association is represented on it by all members of the Council on Medical Education and a member of the Board of Trustees.

Formal Programs. For many years, the American Academy of General Practice has required that its members receive 150 hours of postgraduate education every three years under pain of expulsion. Two state medical associations, Oregon and Oklahoma, have adopted similar policies. In 1968, AMA established an award-incentive program which requires 150 hours over three years to include 60 hours of required education and 90 hours of electives. AMA has stated that state medical associations able and willing to do so may maintain records of such training and make certifications in behalf of physicians. Our association will perform this function.

There are now clearly established two types of programs in continuing or postgraduate medical education: Punitive and incentive. The former requires the training as a precondition to membership, while the latter offers incentives, recognition, and award to physicians meeting minimums. The Mississippi State Medical Association opposes punitive programs and supports incentive and award programs. This position is in keeping with respect for professional prerogative and the clear understanding that he who fails to keep up is left behind.

Institute Program. At the 100th Annual Session, the House of Delegates approved the concept of a Mississippi Postgraduate Medical Institute as an adjunct to the University Medical Center. The Institute is about to become a reality with a first year funding of more than $48,000

under the Regional Medical Program. Moreover, the Institute is a *joint and equal partnership* of the Mississippi State Medical Association and the University Medical Center and is being so funded under a joint grant application. We anticipate second and third year funding of about $60,000 per year. None of this funding relates to a permanent Institute building on the UMC campus which will eventually be sought. We deem it important to establish a viable program before approaching the building project.

> The Institute will serve both physicians and allied professions, including degree, associate degree, diploma, and licensed practical nurses; technologists; technicians; and therapists; and others in the health care field. Pilot programs of intensive on-campus training for physicians have been successfully conducted, and it is anticipated that the formal program will be initiated in the fall of 1969.

There will also be a continuation of the one-time seminars and circuit courses. This category of training will constitute electives as will medical society meetings and hospital staff programs.

Mississippi Program. The council has been engaged in conducting liaison with specialty groups, and one such consultation involved a meeting with the officers and board of the Mississippi Academy of General Practice. In contrast with AMA and AAGP requirements of 150 hours over three years, the Mississippi program will require 440 hours over four years.

(1) Formal minimums will consist of 80 hours annually with two 40-hour weeks on-campus at UMC for intensive, coordinated, organized courses in a clinical environment with faculty instruction, conducted at clinical department level with prepared texts and materials and participation in patient care.

(2) Elective minimums will prescribe 30 hours annually with credit for one-time seminars, circuit courses, and medical meetings of value actually attended at local, state, regional, and national levels. This credit may also be earned for preparation and publishing of scientific papers and for presentation of scientific exhibits at state, regional, and national medical meetings.

Upon completion of the four-year program, a Mississippi physician will have earned a formal academic record and be awarded an appropriate certificate from the University of Mississippi School of Medicine.

New Certifying Board. After many years of patient, serious effort by all concerned, the American Medical Association and the Advisory Board for the Medical Specialties finally and formally approved the American Board of Family Practice as the 20th certifying board in the medical specialties. Diplomates will be recognized by AMA and the Advisory Board. Initially, "practice-eligible" physicians may sit for examination, based on their having completed 300 hours of postgraduate training. For practical purposes, a physician with six years membership in the American Academy of General Practice will be eligible. There is no grandfather clause, and unlike any other American board, recertification will be periodically required. The council has already taken into consideration the need to make any modifications which may be necessary to assist the new specialty.

Expression of the Board of Trustees. At the conclusion of the 100th Annual Session, there was a resignation from the council, and President Rogers appointed Dr. Frederick E. Tatum of Hattiesburg to serve the unexpired term. Other members of the council are Drs. Dennis E. Ward of Corinth who represented the association at the annual AMA Conference on Continuing Medical Education and William O. Barnett of Jackson, our chairman, who is also a Trustee. Dr. Barnett represented the association on a number of occasions in this program, including meetings with the AMA Council on Medical Education.

The Board of Trustees approves the program and commends the council on its energetic and productive work in behalf of all members of the association. We would make no change in policies on the Mississippi program which has been recognized as one of the outstanding such efforts nationally. Rather, we urge a continuation of its development in the interest of a more able profession and improved patient care.

The Board of Trustees and the Council on Medical Education jointly commend the exercise of leadership by Dr. William E. Lotterhos of Jackson who, in his capacity as chairman of the Board of Directors of the American Academy of General Practice, played a key role in the establishment of the American Board of Family Practice.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee notes with pleasure that the program of postgraduate medical education for practicing physicians has been advanced during the year by the Council on Medical Education and the Board of Trustees. We are gratified to learn that the Mississippi Postgraduate Institute in the Medical Sciences is being funded

and that the program will become operational during 1969. We also approve the postgraduate program proposed by the Council on Medical Education and approved by the Board of Trustees which offers incentives to physicians as opposed to punitive programs. We urge the support of every member in this important activity which will ultimately benefit our patients and the practicing profession.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "F" OF THE BOARD OF TRUSTEES

Prior Action. At the 100th Annual Session, the Board of Trustees presented Supplemental Report E, same subject as this report, setting out progress and policy on negotiations with the Department of Health, Education, and Welfare over a health and training program for five Delta counties, Holmes, Humphreys, Issaquena, Sharkey, and Washington. The Board took the position that health care apsects of the program should include:

(1) Criteria for eligibility for program benefits.

(2) Definition of scope and extent of services.

(3) Free choice of physician and hospital.

(4) Compensation of physicians under the concept of usual and customary fees.

The Board also stated to the House of Delegates that "the association must eventually consider the operational program of the project, the policies under which it is managed, the scope and extent of care and the circumstances under which it is rendered, and the actual role which the association will fulfill as relates to the program."

The Board further stated that "it therefore appears appropriate to continue our representation on the project committee, to exert a maximum effort through this representation to shape the program in accordance with the association's wishes, and to monitor carefully program development."

The House of Delegates concurred with the Board of Trustees and requested that representation be continued within the framework of policy as reported by the Board. We are gratified to report that Dr. Temple Ainsworth agreed to continue to make this representation for the association. He has given generously of his time in this connection, and he has continued to meet with the Board to make his reports.

Program Concept. During the 1968-69 year, the program was drawn by the planning task force with recommendations for an annual budget of $3.4 million and a first year start-up funding of about $2.5 million. The budget was apportioned among the three parts of the program with provision for a central staff and a contingent of 10 per cent:

(1) *Part I, Expanded County Health Services.* Emphasis was placed on expansion of county public health facilities and clinics to provide a family-centered approach to health care, underscoring maternal, infant, and child care. Part I provides for additional personnel, physicians and public health nurses, in the five counties. Initially proposed criteria for eligibility are family income under $500 per year per family member for families of six or more and family income under $600 per year per family member for families of five members or less.

(2) *Part II, Vendor Medical Program.* Initially, this part would have served high-risk obstetrical patients and children who are hospitalized or cared for on an outpatient basis. It was agreed that a fiscal administrator for physicians, services would be appointed on a competitive basis, mentioning Blue Shield and the state medical association. The hospital intermediary is expected to be Blue Cross. Each administrator would be expected to operate for about 5 per cent.

(3) *Part III, Training Allied Health Workers.* Two categories of allied health workers will be trained by the University Medical Center for the program, nurse midwives and health aides in specialties of sanitation, nutrition, social work, laboratory assistant, and supervisor of family health practices. The nurse midwife training program would be 10 months duration and conducted with the assistance of the Johns Hopkins University School of Public Health. The health aide training would be of six months duration.

Funding. On Feb. 5, 1969, a general meeting was conducted at UMC during which representatives of state organizations, institutions, and agencies conferred with a special team from HEW including an Assistant Secretary. It was announced that the program would be limited to a first year funding of $1 million and be distributed among a number of divisions of HEW including the Office of Education, the Health Services and Mental Health Administration, the Children's Bureau, and the Manpower Development and Training Administration.

Final Program Concept. In final concept, the program is divided into two areas, service and training. HEW has ruled that under the funding formula, 10 per cent or $100,000 must come from local sources. To some extent, this may be matching in kind.

The service portion will include the expanded

public health services and a very restricted vendor medical program. Approximately $600,000 will be devoted to this portion of which not more than $300,000 can be devoted to the vendor medical program.

The training programs, all sited at UMC, will be limited to $400,000 of which about $150,000 is for the nurse midwifery training and $250,000 is for the health aide training.

Considerable latitude has been reserved by the Committee of Nine developing and steering the program, including dedication of services to Holmes, Humphreys, Issaquena, and Sharkey counties and doing what is possible in view of restrictions for Washington County. The grant application is pending.

Association Participation. Since discussions on this program were first initiated in 1967, the concept and scope have been altered on a number of occasions. The interest of the association has been related to policy, the circumstances of care, and possible impact on any Title XIX Medicaid program which will be developed in the state. The Board of Trustees recommends no change in the policy of the association in these respects. The Board further recommends that expression of the association's interest in acting as fiscal administrator for physicians' services in the vendor medical program be reserved at this time, subject to evaluation and decision by the Board when the program is funded and participation by the association is invited.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We approve the progress report of the Board on the Delta-HEW Program and we concur with the Board in that judgment should be reserved at this time as to the extent of the association's participation in the program subject to further review and decision by the Board of Trustees. This specifically applies to any role which the association might fulfill as fiscal administrator of the program. Accordingly, we recommend adoption of the report.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "G" OF THE BOARD OF TRUSTEES

Background. At the 99th Annual Session, the House of Delegates approved a proposal to expand our Central Headquarters Office Building at 735 Riverside Drive, Jackson, and this approval was reaffirmed by the House at the 100th Annual Session. During the course of considering and implementing the project, the association's original architect, Mr. Jay T. Liddle of Jackson, died. The Board retained W. R. Henry, A.I.A., of Jackson, and the project has been continued. During the 1968-69 year, working drawings were completed after approval at each stage by the Board.

Supervision and Financing. The Board designated the Executive Committee as the Building Committee. Through the assistance of the chairman of the Council on Budget and Finance who is also vice chairman of the Board of Trustees, a number of financing plans were considered. The Board, after careful deliberation, approved a plan under which necessary financing may be arranged on a one-year-at-a-time basis with the interest at the prime rate. Moreover, this plan guarantees the integrity of present amortization at the highly favorable rate of 4.25 per cent. The original building will be paid out in July 1971.

The wisdom of the building project has been demonstrated many times but never more vividly than in a certified appraisal made in February. Our land parcel on Riverside Drive, purchased in 1954 for $12,500 is now valued at $113,000. The entire project with the addition proposed is valued at $254,000. The appreciation has been substantial, and we have enjoyed the use of the building for less than comparable rental space would have cost.

The Board engaged a professional estimator and has invited bids from six large, highly reputable construction firms. We are awaiting the bids, and it is anticipated that the urgently needed addition will be under construction by early summer.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee was gratified to receive the encouraging progress report on our building addition and to learn that bids have been invited from reputable construction firms for the project. We approve the financing selected by the Board of Trustees under prior authorities granted by this House of Delegates and we urge that the addition be completed as soon as possible to fill the need for this additional space.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "H" OF THE BOARD OF TRUSTEES

Prior Action. At the 100th Annual Session, the House of Delegates approved a proposal to appoint the Nominating Committee one year in advance, charging it to consult with colleagues and prospective nominees as to willingness and ability to serve, if elected, to conduct a formal

(Turn to page 380)



The President Speaking

'Warranty of Integrity'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

THERE ARE MANY delightful side benefits to be found by physicians as they face the wonderful opportunity for service to their fellow man. Not least of these is the privilege of working with colleagues who meet the very highest standards of integrity and honor. As I travel about the state attending meetings, observing physicians at work, recognizing the quality of their relationship with the people of the community, I find myself grateful to be a member of this group. Being physicians, we at once have a great privilege and an awesome duty, and I find that with very few exceptions the physicians of our state meet this responsibility with honor and credit to themselves and the profession.

Occasionally, however, we are saddened to learn that one of our colleagues, through greed or dishonesty, has brought discredit to himself and the profession. This seems increasingly more frequent since third parties such as insurance companies and government-sponsored programs have entered the relationship between the patient and physician.

We must create within our professional group the machinery necessary to identify and correct improper behavior. One promising method, the utilization review committee, has been created by fourteen of the eighteen component medical societies. I feel sure there will be infrequent need for these or similar committees to function, but, whenever questions arise, we must be prepared to quickly evaluate them and, where necessary, take appropriate action. It is essential that organized medicine police its own ranks and demand of its own members not only the very highest standards of professional skill but absolute integrity and honor in all matters. ★★★

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EDITORIALS

USA v. CAP: Compromise of a Distressing Saga

I

If the nation's pathologists are a conspiratorial bunch of scheming monopolists, then the U. S. Department of Justice has struck a blow for liberty and freedom of commerce. But, if on the other hand, the pathologists with sincere, scientific, and moral motivation have done their best as physicians to assure quality laboratory services, score another one for lop-sided litigation before the steamroller of big government.

A consent decree was recently reached in the suit styled *United States of America v. College of American Pathologists*. The three-year long hassle was an antitrust action instituted against the specialty on a nationwide basis.

The decree was signed minutes before the College's Assembly (house of delegates) was to meet in special, called session in June, and the action of the leadership was overwhelmingly endorsed by the representative, policy-making body. By no means does it constitute an abject surrender. In fact, neither party to the issues makes any admission on the charges brought in 1966 under the Sherman Antitrust Act.

In general, the College agreed to uphold the laws of the United States and to engage in no activity which could be construed as conspiratorial or dictatorial. It did, and it said that it had never done such things. But there is a note of distaste in the whole affair, because nobody conceives of the College of American Pathologists as a modern day Jay Gould cornering the gold market and establishing rail tariffs at personal whim.

As the College has said, the consent decree represents a compromise and disposes of time-consuming and expensive litigation. Individual members of the College are not bound by the decree, an unusually significant victory for pathologists. But whatever the plus and minus aspects, all of American medicine will do well to note with serious concern that the cause was brought in the first place; there are still 19 other medical specialties to whom the same thing can happen.

II

The suit was filed by the Department of Justice on July 7, 1966, in the United States District Court at Chicago. The College was charged with price-fixing and boycott agreements to keep nonmembers out of the medical laboratory. It was a landmark action, because it was the first antitrust case ever brought against a segment of the medical profession on a nationwide basis.

The burdens imposed upon the pathologists by the litigation were unbelievable: Three years of excessive demands upon leadership and staff resources and legal fees in six figures, even though the matter never went to trial. And henceforth, every activity of the College must be examined in the light of the decree which also *applies to any other individual or organization dealing with the College on any matter restrained by the decree.*

In a nutshell, the decree enjoins and restrains the College from directly or indirectly:

—Restricting, preventing, or attempting to restrict or prevent anyone from organizing, owning, or operating any laboratory (with no minimums as to qualification specified).

—Restricting or preventing anyone from referring any specimen or patient to any laboratory or obtaining laboratory services from any laboratory.

—Restricting or preventing anyone from performing laboratory services for any person.

—Restricting or preventing anyone's associating or affiliating with any laboratory or being employed by any laboratory.

—Requiring or coercing any other person to refrain from accepting advertising from any person or refuse to permit any person to exhibit at any medical or scientific meeting.

—Boycotting or otherwise refusing to do business with or imposing any sanction or penalty upon any person because such person does business or associates or affiliates with or is employed by any laboratory.

—Requiring or coercing or attempting to require or coerce any person to adopt, adhere to, or enforce any criteria established by the College with respect to the compensation to be paid by any hospital to any laboratory or laboratory director, or the purchase or rental by a laboratory or laboratory director from a hospital of space, services, supplies, or equipment.

The decree also enjoins the College from requiring or suggesting that laboratory fee schedules be the same or substantially the same for laboratories in the same locality. And no action may be taken to prevent any laboratory from deciding its own fees.

III

But the College isn't unfrocked as a professional entity or emasculated as a specialty society, either. The decree specifically recognizes the prerogatives of the College in establishing performance standards for operation and accreditation of medical laboratories through an inspection system. It must, however, make the service available upon an impartial basis to all.

The College retains its full rights of imposing sanctions and disciplinary action on members found, after investigation, to be deficient in moral character or professionally incompetent. Moreover, it may require its members to report the results of laboratory tests only to physicians and others permitted by law to receive such results.

The breadth and generality of some restrictions are such that many a medical organization may find itself relaxing a policy here and there. Some may feel that journal advertising pages ought to be opened to industrial laboratories, as the AMA has seen fit to do even before the consent decree. Some may feel it appropriate to open their exhibit halls to these laboratories or even to the repackagers on the premise that a sufficiently strong legal precedent has now been recorded.

But on second reading, there is really nothing in the consent decree that mandates all-out permissiveness in letting the bars down to any quack with a nostrum in interstate commerce. Let it be hoped that the faint-hearted are few and that sincerely held policies and principles are set aside only by due process, not fear and trembling.

IV

The overtones, however, are clear, and the precedent is not to be dismissed lightly. Any profession is a monopoly of sorts, at least to the extent that you can't buy an appendectomy from Sears or Texaco. There is also another key issue at stake in the rights and prerogatives of the states to prescribe legal minimums for professional practice. While this prerogative is not an issue in *United States of America v. College of American Pathologists,* there is no denying that medical organizations can and do exercise quasi-official functions under state law.

The Mississippi State Medical Association possesses all sorts of duties, responsibilities, and authorities under Mississippi law. Were such quasi-official functions enjoined or impeded by a federal court, the state itself would thereby be affected. And the same is true for the dentists, the architects, and veterinarians, and a host of licensed professions.

Finally, if it happened to the pathologists, why can it also not happen in one form or another to the pediatricians, the surgeons, family physicians, or any other specialty? This is a legal possibility, even beyond application of the present decree to others.

The first Medihaler was developed for the physician-inventor's own child.

The improved model you prescribe today is still made with the same painstaking devotion.

When your patient is in the grip of bronchospasm and reaches for his Medihaler, it must work. Not sometimes. Not most of the time. *Always.*

This is the ideal of perfection which has motivated the constant process of improvement of Riker's Medihaler.

Since its invention in 1956—when a Riker physician developed the Medihaler because of his determination to make better treatment available for his own asthmatic child—Riker has pioneered just about every significant forward step in bronchodilator aerosol therapy.

Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

Riker was first to formulate medication in a non-irritating, non-alcoholic vehicle.

Riker pioneered pre-grinding of the medication to 1-5 micron size, assuring maximum distribution to the distal bronchioles for greater topical effectiveness with less systemic action. (Oddly, even today not all competitors have adopted these two advances.)

Add to these advantages a quality control system involving 168 physical measurements and chemical tests, plus not one but two test firings on every single unit leaving the plant, and you can readily see why there is no more dependable relief for bronchospasm than your prescription for Duo-Medihaler or Medihaler-Iso.

Please see next page for complete prescribing information.

Medihaler-Iso®
(isoproterenol sulfate)



Duo-Medihaler®
isoproterenol HCl (4mg./cc.)
phenylephrine bitartrate (6mg./cc.)

Riker Laboratories, Northridge, California 91324

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SUMMARY OF PRESCRIBING INFORMATION

DUO-MEDIHALER®

(isoproterenol hydrochloride and phenylephrine bitartrate)

Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories Northridge, Calif. 91324

The College has fought the good fight, and its leaders and members are deserving of understanding and admiration. They are physicians first and pathologists second. Let none be smug because of specialty: On the basis of this suit, it is not altogether speculation and fiction that a medical organization might someday be enjoined against preventing a computer company from making diagnoses. These are the strange roads over which the forward thrust of medical science must travel. And too many rocks and potholes could lengthen the trip.—R.B.K.

The Private Sector, the Inner City, and Medical Care

That behemoth of the financial community, the life insurance industry, is turning in a good performance by using private enterprise to fight slums and the depression of the inner city. Two years ago, the industry pledged $1 billion for rebuilding and rehabilitation of the crumbling innards of urban areas, and since that time, the ante has been upped to $2 billion.

As of mid-1969, the industry has actually committed $900 million in private, nongovernmental funds for construction of 18 hospitals, 34 nursing homes, 11 clinics, and 11 medical buildings. A similar governmental commitment might have cost the taxpayers twice that amount. In less than a year, $126 million of the commitment has been closed in ongoing projects.

In addition to the notable gain in medical facilities for the private sector, the project has created about 15,000 new jobs. President Nixon observed that the program "would have an impact far beyond what is directly accomplished by this particular investment."

He explained that "the effectiveness will be multiplied many times by providing economic stimulation, by inspiring further investments, and by encouraging greater cooperation between private and public institutions."

The remarkably unusual private capital venture will not necessarily be profitable to the insurance industry. It is high risk financing as regards housing and general business structure rehabilitation, although the medical facilities portion carries no undue hazard to the lenders. Perhaps the greatest service is the availability of the funds in the present tight-money, high interest market. The project is far more than a public relations gesture by a major industry, because the commitment is so substantial.

This responsible discharge of corporate citizenship within the private sector is a heartening sign as well as an index to what can be done without tax-supported giveaways.—R.B.K.

AMA: Not Even the Appearance of Evil

Very quietly, unobtrusively, and most important, voluntarily, the American Medical Association's Board of Trustees has acted to prevent conflicts of interest in high levels of medical organization. This commendable decision underscores what nearly everybody already knows: The worst conflicts of interest are not in government but rather in private business and key professional and business organizations.

All AMA staff executives have subscribed to a nonconflict of interest pledge. It is understood that officers and elected officials are keenly aware of potential interests conflicts and are acting voluntarily to resolve any suggestion of personal involvement.

The Board of Trustees has revised the association's investment policies, too. No AMA funds shall be invested in any company whose primary activities make it part of the pharmaceutical industry. No AMA funds may be invested in obligations of foreign governments or in companies whose operations are conducted primarily outside the United States. And no AMA investment shall be of such size that under ordinary circumstances the association would have a significant voice in the management of the company.

Ever since the first businessman of a publicly held organization bought his insurance from his brother-in-law, otherwise innocuous acts of patronage have grown into outright schemes of self-profit. Often, these conflicts grow into potential antitrust situations, because the greedy and avaricious find it necessary to control increasingly larger segments of business activity to maintain their personal profit sources.

Usually, a conflict of interest turns out to be nothing more than the appearance of evil, but this is to be avoided like the plague. AMA has not only acted wisely but it has also taken an extra measure of protection to assure the integrity of the profession and the high responsibilities it carries.—R.B.K.

Updated Policy, Enlightened View

The Chamber of Commerce of the United States has revised its policy on Medicare. As a result of a membership referendum which brought an impressive 86 per cent endorsement of the majority view, the Chamber has cast aside its unqualified opposition to any sort of compulsory medical and hospital insurance program. But it really hasn't changed its views on such a program for everyone.

The Chamber adopted guides for evaluating Medicare on the logical and rational premise that it's here. The guides state that the program should be pay-as-you-go, and if compulsory as Medicare happens to be, it should be financed with taxes on earnings and payrolls only, as is not the case at present. The government's $4 per month share of Part 1-B costs comes from the general kitty.

Where such a program is compulsory, the Chamber says, wandering into a little wishful thinking, at least one-half of the costs should be paid by beneficiaries. The Chamber, with stern realism, feels that proper utilization safeguards should be erected, that benefits should be applicable only to care costs with significant economic impact, and that vendors and providers ought to be paid in full at the going price.

Minimizing the influence of government, the Chamber says that tax-supported programs ought to be run by nongovernmental organizations and that benefits ought always to be limited to those over age 65.

The directors of the powerful business group said that "adopting a timely and realistic policy on Medicare for the aged does not affect the Chamber's position on the issue of a universal health care program." This our business community opposes. The directors explained that the new policy merely permits the Chamber to go before the Congress with pertinent testimony on proposals to expand or liberalize the program.

The Chamber's view is enlightened, because it indirectly represents a vast majority of the business and financial community in the nation. And these employers bear a huge share of the tax bite for Medicare as regards payroll taxes. Additionally, the response of the membership on the carefully considered referendum shows what businessmen are thinking. The Chamber's action should open a new area of discussion and make the Congress think twice before using Social Security amendments as campaign gimmicks.—R.B.K.

The Liberals Go for Family Planning

A brand new bill on family planning, S. 2108, is before the United States Senate, but the measure itself is of questionable parentage. Twenty-two senators are co-sponsoring the proposal, and a list of their names reads like the board of directors of Americans for Democratic Action.

The chief sponsor, Sen. Joseph D. Tydings (D., Md.), says that the bill is aimed at breaking the "vicious circle of poverty and fertility . . . " which results in families without hope and children without future. He is joined in his beliefs by a score of liberal senators on both sides of the aisle.

The Tydings proposal would consolidate the many family planning activities of the Department of Health, Education, and Welfare under a single agency which would be designated as the National Center for Population and Family Planning. It would be generously funded to the tune of $89 million for the first year.

The five-slice pie offers $30 million for additional project grants, a sop to the Nixon administration which has consistently opposed the old formula grants for health-related purposes. State programs would get $10 million across the board, $2 million is for training, $35 million would be earmarked for research, and $12 million is slated for research facilities construction. Moreover, the program includes the popular device of back door financing, since the law outlines five years of progressively mounting activities with only one year's financing.

Sponsorship and methodology do not, unto themselves, make an idea all bad. The population problem of the 1960's has vindicated and venerated Malthus whose biomedical and agricultural insight was pretty good. American medicine has recognized responsibilities in family planning which neither conflict with nor supersede the overriding social and moral issues involved.

To say the very least, the Tydings bill can furnish a convenient vehicle for informed and serious discussion in relating this vital issue to national policies and priorities.—R.B.K.

POSTGRADUATE CALENDAR

SPECIALIST OF THE DAY

Beginning in September, the Mississippi Regional Medical Program and the University of Mississippi School of Medicine will again provide Specialists of the Day for hospital medical staffs who request them. Under this MRMP funded program, specialists in various disciplines spend a half day in lectures and ward rounds in local hospitals. Medical staffs may ask for faculty by name or by discipline, addressing their requests to Dr. W. O. Barnett at the Medical Center.

FUTURE CALENDAR

September 25

SURGICAL ASPECTS OF VASCULAR DISEASE

October 7

SOUTHWEST CIRCUIT COURSE, MCCOMB

October 23, 30, November 6

NORTHERN CIRCUIT COURSE, GREENWOOD

April 1-3, 1970

CARDIOVASCULAR SEMINAR

NEW MEMBERS

The following physicians have been elected to membership by their respective component Medical Societies in the Mississippi State Medical Association and the American Medical Association.

BLOUNT, RICHARD LAMAR, Jackson. Born Memphis, Tenn., Sept. 29, 1936; M.D., Baylor University College of Medicine, Houston, Texas, 1962; interned Grady Memorial Hospital, Atlanta, Ga., one year; ophthalmology residency, Baylor University College of Medicine, Houston, Texas, July 1, 1963-June 30, 1966; fellowship, Heed Ophthalmic in Pediatrics, July 1, 1966-Jan. 1, 1967; elected May 6, 1969 by Central Medical Society.

JACKSON, JOHN RUSHING, JR., Hattiesburg. Born Hattiesburg, Miss., Oct. 17, 1936; M.D., University of Mississippi School of Medicine, Jackson,

1962; interned U. S. Naval Hospital, Portsmouth, Va., one year; pediatric residency, Baylor University College of Medicine, Houston, Texas, July 1, 1966-June 30, 1968; elected March 13, 1969 by South Mississippi Medical Society.

LAMPTON, THEODORE DUDLEY, Jackson. Born Tylertown, Miss., April 25, 1937; M.D., University of Mississippi School of Medicine, 1962; interned University of Texas, Medical Branch, Galveston, one year; medicine residency, University Medical Center, Jackson, Miss., July 1, 1963-June 30, 1966; fellowship, medicine and neurology, University of Alabama Medical Center, Birmingham, July 1, 1966-June 30, 1967; elected May 6, 1969 by Central Medical Society.

SHERLINE, DONALD MORTON, Jackson. Born Utica, New York, Nov. 19, 1931; M.D., Northwestern University Medical School, Chicago, Ill., 1958; interned Chicago Wesley Memorial Hospital, Chicago, one year; obstetric and gynecology residency, Evanston Hospital, Ill., July 1, 1959-June 30, 1962; fellowship, obstetric anesthesiology, University Hospital, Cleveland, Ohio, July 1, 1968-Dec. 31, 1968; elected May 6, 1969 by Central Medical Society.

DEATHS

CASHMAN, GEORGE A., Bay St. Louis. M.D., Columbia University College of Physicians and Surgeons, New York City, New York, 1918; retired from private practice in New York City; died June 6, 1969, aged 79.

COE, JAMES EDDY, Lambert. M.D., University of Tennessee College of Medicine, Memphis, 1937; interned St. Joseph's Hospital, Memphis, Tenn., one year; died June 18, 1969, aged 57.

LEIGH, ROBERT MATTHEWS, Columbus. M.D., Tulane University School of Medicine, New Orleans, La., 1912; interned City Hospital, Nashville, Tenn., one year; trained at Tulane, 1928-1932; died June 7, 1969, aged 82.

WARREN, GEORGE TORREY, Brookhaven. M.D., Tulane University School of Medicine, New Orleans, La., 1909; interned Natchez Hospital, 1911-14; Emeritus member of MSMA; member of the MSMA Fifty Year Club; died May 30, 1969, aged 84.

LETTERS

SIRS: In the JOURNAL editorial "Kudos for the College," J.M.S.M.A. X:261 (June) 1969, you omitted Howard Memorial Hospital in Biloxi in your listing of Mississippi hospitals having an ACS-approved tumor registry.

Howard Memorial Hospital in Biloxi has an active tumor registry under the aegis of the American College of Surgeons. Our registry has been functioning actively for almost two years. That gives the Coast three of the six registries in the state of Mississippi.

A registry requires the active interest of several staff members; the presence in the hospital of certified radiologists, pathologists, and surgeons as well as extra clerical personnel and space. Rewards occur in terms of self-evaluation of tumor results, follow-up of cancer patients and material collected for future study purposes. We encourage more hospitals to join us in the never-ending fight against cancer by establishing more local tumor registries.

WARREN C. PLAUCHE, M.D.
CHIEF OF OBSTETRICS AND GYNECOLOGY
HOWARD MEMORIAL HOSPITAL
BILOXI

(The omission of Howard Memorial Hospital as having an ACS-approved tumor registry was not only inadvertent, but it was also a result of the American College of Surgeons not listing Howard Memorial. Both the ACS principal and supplemental listings for 1968 and 1969 omit the hospital. Our commendations for the good work and apologies for the unintended omission.—*The Editors)*

PERSONALS

WARREN BELL of Jackson was among registrants at a New Haven, Conn. meeting of the Academic Clinical Laboratory Physician and Scientists.

JOHN D. BOWER of Jackson received an award for outstanding service to those afflicted with disease of the kidney through dedicated efforts in support of the Kidney Foundation of Mississippi at the annual membership meeting.

THERESA L. R. BUCKLEY of Biloxi was installed as president of the Altrusa Club of Biloxi at the club's recent meeting in the Buena Vista Hotel.

GUY CAMPBELL of Jackson participated in a workshop for regional medical program coordinators at the University of Chicago's Center for Continuing Education in early June.

P. TEMPLE CARNEY of Clinton announces the opening of his office in Clinton Plaza on July 1 for the family practice of medicine.

ROBERT E. CARTER of Jackson joined medical educators from across the nation in a seminar on "Medicine in the Ghettos" at Portsmouth, N. H. The June program was sponsored by the Harvard Medical School, the Boston Globe and the National Center for Health Services Research and Development.

W. H. DUDLEY, JR. of Whitfield recently spoke to a social welfare conference on the problems of the aged.

LEONARD W. FABIAN of Jackson was consultant in anesthesiology at Lackland Air Force Base, San Antonio, Texas and visiting professor of anesthesiology at Baylor in mid June.

JOHN M. FORD of Baldwyn and CHARLES M. MURRY of Oxford are two of the physicians on the medical staff of Region V for the Seventh National Jamboree, Boy Scouts of America at Farragut State Park, Idaho.

EARL W. GREEN, JOHN E. GREEN and EMMETT M. HERRING, all of Hattiesburg, announce their discontinuation of ear, nose and throat treatment and surgery, effective July 1, 1969. They will limit their practice to diseases and surgery of the eye at the Green Clinic, 705 Hall Avenue.

D. W. HAMRICK of Corinth has been elected president of the Mississippi State Board of Health. The eye, ear, nose and throat specialist will preside over all meetings of the State Board which governs the 82 health departments in the state, the state hospitals, health agencies and examines for licensing physicians.

JAMES D. HARDY of Jackson served as chairman of the first session of the second World Heart Transplant Symposium in Montreal. More than 100 of the world's top transplant authorities took part in the scientific sessions.

BERNARD T. HICKMAN of Jackson addressed the spring meeting of the Louisiana Regional Medical Program in New Orleans.

BEN B. JOHNSON of Jackson has been elected secretary of the Mississippi Kidney Foundation. He will take office July 1.

SAMUEL B. JOHNSON and GODFREY ARNOLD of Jackson were participants in the spring coast meeting of the Louisiana-Mississippi OO Society.

HERBERT G. LANGFORD of Jackson took part in the Atlantic City session of the American Federation of Clinical Research and an Automated Indirect Blood Pressure meeting in Washington, D. C. this spring.

WILLIAM R. LOCKWOOD of Jackson was in New Orleans recently to do a bacteriological survey of respiration equipment at the Tulane School of Medicine.

HENRY LYNCH of Rolling Fork was elected alderman in the city's June 3 election.

DENNIS E. MAGEE of Picayune announces his affiliation with the Associated Medical Center at 139 Kirkwood. He was formerly county health officer for Pearl River and Hancock Counties and a member of the Massey-Magee Clinic in Picayune.

JAMES B. MARTIN of Monticello has been elected to active membership in the American Academy of General Practice.

SAMUEL O. MASSEY, formerly of Picayune, is joining Charity Hospital in New Orleans where he will specialize in diseases of the ear, nose and throat.

CHARLES A. OZBORN of Eupora will resume his practice there after two years of military service. He will join the Community Clinic staff.

DONALD SHERLINE, ROBERT E. CARTER and HENRY THIEDE, all of Jackson, and WARREN PLAUCHE of Biloxi took part in a summer UMC OB-GYN Association Seminar. Guest speaker for the scientific meeting was Dr. Beverly Mead, professor and psychiatry chairman at Creighton University, Omaha, Neb.

ROBERT D. SLOAN of Jackson made an inspection tour for the American Board of Radiology in Wichita, Kan. recently.

HENRY THIEDE of Jackson has been elected to membership in the American Gynecological Society.

THOMAS B. WALDON, formerly of Tampa, Fla., is now associated with the King's Daughters Hospital

in Brookhaven. Dr. Waldon limits his practice to pathology.

Elmo L. Walker of Jackson announces the removal of his office from Clinton Plaza to Van Winkle Medical Clinic, 4304 Highway 80 West. Dr. Walker engages in family practice.

David B. Wilson of Jackson was in Dusseldorf, Germany, in mid June to present a paper at the International Hospital Federation meeting.

Book Reviews

Pediatric Therapy. Third Edition. Edited by Harry C. Shirkey, M.D. 1294 pages with illustrations. St. Louis: The C. V. Mosby Company, 1968. $25.00.

This well-illustrated book contains 1,294 pages with 89 contributions, and it is an outstanding book both for reference and general informative reading. With 89 contributions of outstanding sub-specialities in the field of pediatrics, the book has been well edited by the very capable Dr. Shirky, a phamacologist, pharmacist and clinical practitioner in the field of pediatrics.

To this third edition have been added seven new chapters of more recent special interest to the general field of pediatrics as well as other specialties and also general practice. The use of cross-references by related subject matter is also of particular value for a book of this size containing so much information in today's changing field of general therapy.

Also notable about the book are two color sections designed to give quick access to special forms of treatment as convulsions and poisoning. Poisons are listed in alphabetical order with MLD, symptomatology and specific treatment easily obtained for each type of poison.

Another section is a table of drugs listing medications according to classifications under which they may fall, which serves as a quick reference for general pediatric dosages and saves much space in this book replacing specific listing of these under different disease processes.

Timely, appropriate and interesting as well as informative are 13 chapters in the first part of the book on the fundamentals of drug treatment in children. The specifics of drug therapy for different diseases as well as symptomatology follow this in an orderly fashion.

There also is easily accessible information regarding the specific treatment of the disease processes of specific organs and one section devoted solely to the problems of therapy in pediatric surgery. A discussion of the relation of normal to abnormal as well as the emotional, pathological, physiological aspects of disease and an attempt to bring a patho-psycho-physiological interpretation to treatment of disease rather than just give a specific form of therapy for one specific disease make this text unique.

This book, with its general scope, logical intent in therapy and practical application, where feasible, is a worthwhile text for physicians interested in the clinical well being of pediatric patients.

Jack A. Stokes, M.D.

Appraisal of Current Concepts in Anesthesiology. Volume Four. Edited by John Adriani, M.D. St. Louis: The C. V. Mosby Company, 1968. $12.00.

In an era of conglomerates, it is not surprising to find a medical book that can be described as a conglomerate. This book covers a wide range of subjects of particular interest to anesthesiologists and of general interest to doctors in other specialties. It should be established, however, that Dr. Adriani did not write this book. He has collected a group of papers written by his residents in training, and compiled a volume. This book does not compare with Dr. Adriani's other publications which have become classics in the field of medical literature. Each chapter in this volume merely headlines the subject without a true in-depth perception such as is found in the publications for which Dr. Adriani is so well-known. There are fifty chapters all contained within four hundred and forty-three pages. The arithmetic involved precludes any detailed study of the subjects discussed. The most that can be said about this book is that it mentions just about everything that is pertinent in anesthesia.

As in every book, this one has some chapters that are more illuminating than others. The chapter on myoglobinemia and myoglobinuria is one of the more interesting discussions. It stresses a little-appreciated danger of succinylcholine, a commonly-used muscle relaxant. For the theoretically inclined person, the chapters on protein binding of volatile anesthetics offers a bird's-eye view of an interesting concept of the mechanism of anesthesia. The chapter on the relationship of spinal fluid acid-base balance to the control of respiration is one of the few in-depth discussions. It is a concise and clearly presented treatment of a little-understood subject which leaves the reader better informed, and with a desire to pursue the subject further.

There are other chapters which have great potential as far as the subject matter is concerned

but which leave the reader rather frustrated because of the brevity of the discussion. The bibliography is not exhaustive, but this could be a requirement of the publisher. It is disturbing to contemplate why Dr. Adriani would risk his reputation as a medical author with a book like this. Perhaps he was anxious to give some young doctors the opportunity of participating in medical literature. Besides being one of the foremost medical authors, he has also been very instrumental in giving young doctors a helping hand. This book has some value; however, to find a complete discussion of any of the subjects contained in this book, the reader would have to search elsewhere.

In the preface, Dr. Adriani states that "the subject matter is not directed toward research workers, those interested in exhaustive reviews, those who are in advanced training in anesthesiology, or those who are interested in completeness and in massive detail with specific references documenting each statement that is made." These reservations exempt a large segment of potential readers.

THOMAS J. MARLAND, M.D.

Morris Fishbein, M.D., An Autobiography. Morris Fishbein, M.D. 486 pages with illustrations. Garden City, N. Y.: Doubleday & Company, Inc., 1969. $10.00.

Dr. Morris Fishbein has been described as the only man in the world who could sit on the back row in the AMA House of Delegates, simultaneously listening to a speech, writing a rebuttal of it, conducting a press conference, and editing papers for next month's *JAMA* in his spare time.

The autobiography seems as if it were written as a personal communication to selected AMA leaders, past and present, living and dead. But if this were indeed its purpose, it does not in the least detract from the easy reading, almost informal narrative spanning 36 years in the backroom behind the backroom at 535 North Dearborn Street in Chicago.

The autobiography no doubt is exactly what Dr. Fishbein wanted it to be. It is not a history of the American Medical Association (Dr. Fishbein wrote such a work which still stands alone in a class of excellence). Rather, it is a series of footnotes to history written by a gifted observer who was there. It is not devoid of the personal viewpoint or perhaps a little bias, because the author is easily the most controversial figure in 20th century American medicine.

The Fishbein story is one of a ceaseless struggle for scientific excellence in the literature, for



his worst enemies must concede that he is without a peer as a medical editor. It is also an unremitting fight against all shapes and forms of quackery, and he has the lawsuits to prove it. Third, it is a story of a power struggle within the highest circle of medical organization.

Although this struggle is cast against the background of state, tax-supported medical services which Dr. Fishbein opposed with an energetic fervor difficult to describe, it is really a matter of powerful personalities, deep convictions, and the difficult choices which faced medicine in the turbulent 1940's.

The tenor of the work must be pegged as happy, at times almost superficial. For example, Dr. Fishbein relates his casually going to Europe as the AMA Board of Trustees, under the leadership of the legendary Dr. Elmer Henderson of Kentucky, the man who fired him, was in a crisis state.

But the author claims for himself no supernatural powers, and he deliberately ignores many of his monumental achievements in making *JAMA* into the scientific literary giant it is. Dr. Fishbein's hypersensitivity breaks through the calm and otherwise happy narrative when he talks about the California Medical Association. While the record shows that CMA has been in many a squabble over how the AMA shall be run and who will do the running, there can be little justification for the author's remonstrating with such medical statesmen as E. Vincent Askey and John W. Cline. Each has risen to the presidency of AMA.

The work is attractively presented by the publisher, and it is highly recommended to the senior physician who read Fishbein each week in *JAMA* and about Fishbein each day in the newspaper as well as to the young physician who can enrich his knowledge of what medical organization is all about.

ROWLAND B. KENNEDY

Health Screening Given State First-Graders

Hundreds of Mississippi children are getting comprehensive health screening by State Board of Health teams in a program now rounding out its first year.

The program is centered primarily on first-grade school children and is carried out by invitation from the county school system and from the county health department.

Dr. Frank M. Wiygul, of the State Board of Health, estimates that some 2,000 children have been examined in this program since it began in mid-1968 to detect physical conditions which may cause trouble if not found at an early stage.

Dr. Wiygul, director of health education and school health for the state agency, is the medical consultant for the comprehensive health screening for the first-graders.

The program is coordinated at the state level by Theoda H. Griffith, acting supervisor, and by Terry Beck, program coordinator, Chronic Illness Service, State Board of Health.

The county health officer heads the screening team, and volunteer workers are called upon to assist the physicians, nurses and technicians of the State Board of Health.

Abnormal findings are reviewed by physicians who make the proper disposition and recommendation. Children requiring medical attention are referred to their private physician.

A current project is the screening of some 370 first-grade pupils in Head Start centers in Clarke county, plus about 30 other children in a private kindergarten.

Dr. Frederick L. Risher, of Shubuta, is the county health officer for Clarke and Wayne counties, and he heads the team of local State Board of Health nurses. State Board of Health technicians work out of Jackson.

The screening sessions are conducted each Monday from 9 a.m. to 3:30 p.m. at Clarke County Health Department locations in Quitman, Shubuta and Enterprise.

Pediatric consultants for Head Start programs in Mississippi have been notified by the State Board of Health that these screenings are available for Head Start children in areas where medical examinations are not available because of lack of medical coverage or lack of physicians. The screenings do not replace any existing medical arrangements or contracts.

Height and weight are recorded for each child, and consultations are scheduled with a State Board of Health nutritionist for all children who appear to be grossly malnourished.

A technician uses a PhonoCardioScan (a machine which listens to the heartbeat) to pick up any abnormal heart sounds. Other tests check vision and hearing.

The screening also includes routine throat inspection, tuberculin skin test, blood test for anemia, dental inspection, urine test, stool specimen and a check of obvious physical defects.

The screening involves State Board of Health divisions in chronic illness, dentistry, nutrition, maternal and child health, heart disease control, local health services and nursing service, and all samples are sent to the State Board of Health.

AMA's Legislative Program Takes Initiative

The American Medical Association's legislative program has taken on a new dimension. In an attempt to emphasize the medical profession's leadership and to utilize its knowledge and experience in the health field, the AMA has shifted from "reaction" to "action."

In the past, the AMA often awaited the introduction into the Congress of legislative proposals on health matters before offering its comments to the concerned Congressional committees. Now, it has initiated a number of proposals to improve the health care of the American people. Through its awareness of the health needs of the nation, the AMA has taken on the new responsibility for drafting bills and seeking to introduce them into the Congress.

This shift in emphasis should alleviate much of the past criticism for the AMA's previous post facto reaction to bills because the AMA should have been expected to initiate and counsel on its own recommendations, the critics claim.

Through greater *early* initiative and the actual drafting of proposals by the AMA legal staff, at the direction of AMA leadership, a number of bills are already under consideration in this Congress which directly affect the provision of health care. Among them are proposals to provide veterans with an option to receive hospital care in facilities other than those of the Veterans Administration; to provide for a National Commission on Health Resources for Medical Manpower and for an Assistant Secretary of Defense for Health Affairs; to amend the antitrust laws to permit physicians, hospitals and non-profit blood banks to obtain blood and blood plasma from blood banks of their choice; and to amend the Social Security Act to provide greater psychiatric benefits under Titles 18 and 19.

Other bills which the AMA Board of Trustees is now reviewing cover the establishment of a Cabinet level U. S. Department of Health; the exclusion of chiropractic services from state Title 19 programs; the amendment of the income tax law to allow medical expenses as a full deduction; the permission for professional associations to be taxed as corporations, and the provision for Congressional review of regulations promulgated by federal agencies.

Too Many Hospital Visitors Prove Harmful

The North Carolina Committee on Patient Care, recognizing the burden to both patient and staff of excessive and prolonged hospital visits, conducted a study to determine the extent of the problem. It asked the Department of Hospital Administration at the University of North Carolina for its assistance in this inquiry and it found that over 50 per cent of the surveyed hospitals expressed discontent with current visitation practices.

The Committee then established demonstration projects in a rural and metropolitan community hospital to which lay and professional persons were appointed to identify problems of excess visitations and to devise programs for changing visiting patterns.

The members recommended stricter visit practices and developed programs to educate the public to respect hospitals' visitor regulations. The two committees also conducted in-service training classes for hospital personnel.

A year after the first study, a follow-up survey revealed that visit traffic had been reduced by more than 50 per cent in the rural hospital and by over 30 per cent in the urban hospital.

The results of this successful study were reported by the Committee on Patient Care to the Executive Committee of the Medical Society of the State of North Carolina, the North Carolina Hospital Association and the North Carolina Nurses Association, and in 1968 these organizations adopted the Committee recommendations for improving and expediting visitor programs in hospitals throughout the state.

Copies of the study and findings may be requested from the North Carolina Committee on Patient Care, 1500 North Carolina National Bank Building, Charlotte, N. C. 28202.

MTRD Launches "Quit Smoking" Effort

The Mississippi Tuberculosis and Respiratory Disease Association will mail an easel-back $8\frac{1}{2}'' \times 11''$ counter card display and accompanying educational pamphlet to every physician in Mississippi as a part of their educational effort to distribute information about the hazards of smoking.

The eye-catching poster carries the message, "Try a Brand New Switch—Quit."

Our travel-pak for summer cold and allergy sufferers.

Novahistine LP can speed your patients on their way, by providing prompt and continuous relief from the symptoms of summer colds and allergies. These continuous-release tablets contain a vasoconstrictor-antihistamine formulation that goes to work rapidly and lasts for hours. Even when nasal congestion is caused by repeated allergic episodes, the convenient twice-a-day dosage of Novahistine LP makes it easy for most patients to enjoy relief all day and all night. When symptoms are severe, a third dose of one or two tablets may be safely given. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

UMC Awards 75 M.D. Degrees

Seventy-five UMC seniors joined the ranks of the physician population when Chancellor Porter Fortune awarded them M.D. degrees. Also receiving degrees at the ceremony were nine Ph.D.s, five master of science and twenty bachelor of nursing degrees.

Other commencement activities included the alumni breakfast at the Hotel Heidelberg and the Chancellor's reception in the School of Nursing auditorium.

The largest number of students in the University of Mississippi School of Medicine's history received their doctor of medicine degrees in the school's 13th annual commencement June 8 at Jackson's Municipal Auditorium.

Dr. Leon Jacobson, dean of the division of biological sciences and the Pritzker School of Medicine at the University of Chicago and one of the nation's most distinguished medical educators, delivered the commencement address on the future of medical education.

Caleb Fiske Essay Subject Announced

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize Essay of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Medical Education in the Years Ahead." The essay must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submitted by December 15, 1969.

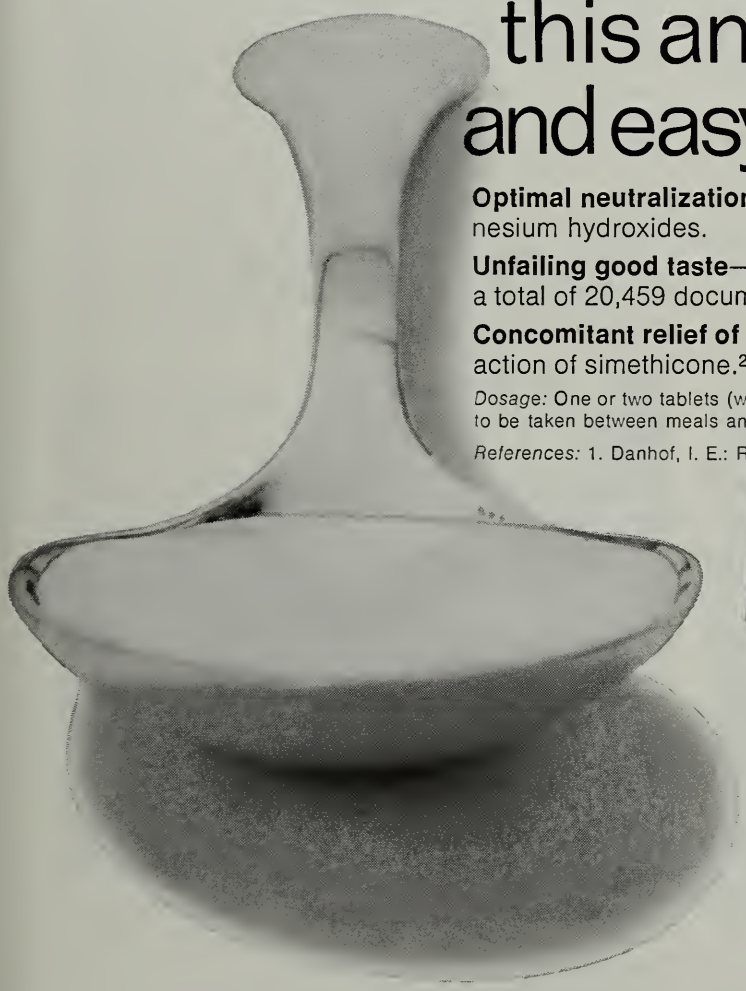
For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.



The ceremony principals included, from left: Chancellor Porter L. Fortune, Dr. Thomas L. Windham of Jackson, recipient of the medical school's Waller S. Leathers award for academic achievement, Dr. Leon Jacobson, commencement speaker and University of Chicago School of Medicine dean, Margaret Valentine of Jackson, winner of the School of Nursing faculty award for outstanding graduating student, Miss Christine Oglevee, nursing school dean, and Dr. Robert Carter, medical school dean.

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Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

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MSMA Construction Continues on Schedule

Construction on the addition to the association's Central Office Headquarters Building is proceeding according to schedule, report Dr. James L. Royals of Jackson, MSMA president, and Dr. Mal S. Riddell, Jr., of Winona, chairman of the Board of Trustees and of the Building Committee.

Priester Construction Company of Jackson, general contractors, began construction in mid-June. The contract calls for completion in 180 days.

Excavation for the lower level is now completed. The extensive foundation work, poured-in-place, bell-bottom piling which is steel-reinforced is in progress.

The excavation goes down to an average depth of 26 feet, well below the marl strata which gives foundations in Hinds County such trouble.

Site clearing has been completed and the rough grading is underway. When this phase is finished, the foundations will be reinforced concrete on which structural steel will be erected.

The addition was initially authorized by the House of Delegates in 1967 but the project was deferred when the original architect, Jay T. Liddle, A.I.A., of Jackson, died. W. R. (Bob) Henry, A.I.A., also of Jackson, was retained in 1968 to complete planning studies and final plans and specifications.

Dr. Royals said that the new addition will be to the rear of the existing building, occupying two levels. It will provide almost 5,000 additional square feet of usable floor space and storage, bringing the total amount to 12,000 sq. ft.

Overseeing the project details is the Executive Committee of the Board of Trustees whom the Board designated as the Building Committee. The group consists of Drs. Mal S. Riddell, Jr. of Winona, chairman; J. T. Davis of Corinth; and William O. Barnett of Jackson.

The addition will furnish needed office space for the Membership, CHAMPUS and JOURNAL departments. At the lower level will be mechanical, storage, mail and mimeograph rooms. There will also be some renovation of the existing building, including painting and some repairs and replacements.

The new construction will be of the same quality as the original building with slab-over foundations, steel framing and masonry exterior. Interiors will consist of paneling, masonry, and dry wall construction with suspended ceilings and high intensity lighting. Floor covering will be vinyl and carpet.

Maximum insulation and minimum exterior openings will assure economy on heating and cooling.

The project includes expansion of offstreet parking, enlarging the existing facilities to accommodate 32 automobiles.

The association's property consists of 187 front feet on Riverside Drive which runs to a depth of 251 feet. It was purchased in 1954 for $12,500



Construction principals constantly oversee the action as the heavy machinery whittles away at the earth. Left to right (left photo) are W. R. Bob Henry, A.I.A., Jackson, architect; W. F. Bullock, general superintendent, Priester Construction Co.; and Q. E. McCain, project superintendent. Advance preparation for laying the foundation progressed according to schedule despite some rain and the intense heat.



and is now valued at $113,000 without the building and improvements.

Financing has been arranged by the Board of Trustees and the Council on Budget and Finance at the prime interest rate. The original building loan is to be paid out in 1971 and will not be refinanced. The initial amortization carries a 4.25 per cent interest rate which the Board was anxious to protect.

Dr. Royals said that completion is estimated before Christmas.

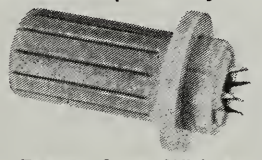
Miami Sponsors Nov. ENT Course

The University of Miami School of Medicine, division of otolaryngology, will present a postgraduate course in ENT for the family practitioner. The course will be held Nov. 6-7, 1969 in Miami Beach.

Course director is Dr. Fredric W. Pullen, II, division of otolaryngology, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 44 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



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CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
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ALABAMA HOSPITAL ASSOCIATION . . .
BIRMINGHAM REGIONAL HOSPITAL COUNCIL:
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals and is also approved for Medicare patients.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

Marion County Memorial Book Begun

Research is currently underway in Marion County, Miss. to discover facts about doctors who practiced there for a book entitled "Marion County Men of Medicine." The volume will be placed in the Shelby Memorial Library at Columbia.

Project coordinators especially need biographical information and pictures of deceased doctors and those practicing in the last century and early days of this century. Information on their training and any interesting incidents or anecdotes connected with their practice will also be used.

Families of doctors who desire their professional member and his service to be represented in the book should contact Mrs. Charles Thompson, Jr. All original clippings and photographs will be copied and returned to families who wish to keep them.

Among the physicians about whom information is being sought are Doctors Henry Hardy Dale, Theodore Buckley Ford, Manson L. Banks, George Albert Brumfield, William Woodard Applewhite, James G. Cherry, John J. Dearman, Henry Franklin Hart, Louis D. Dickerson, Joseph M. Thornhill, Albert Wain Johnston, Henry Reynoldson Curtis, Richard L. Loyd, James Q. Fountain, W. D. Ratliff, Virgil M. Bass, Joel J. Goss, William Harmon Davis, and William Bonner.

Two Mississippians Get M.D. Degrees From Vanderbilt

Two Mississippians were among honor students graduating from Vanderbilt College this spring. Dr. William Joseph Anderson of Jackson received the Founder's Medal of achievement for compiling the highest overall scholastic record while at the college.

Dr. Anderson entered Johns Hopkins Medical Center in Baltimore July first for an internship in surgery.

Dr. Wyatt Easterling Rousseau, a Jacksonian, also graduated with scholastic honors. He is interning at Parkland Memorial Hospital in Dallas and plans to specialize in obstetrics and gynecology.

Both physicians hope to practice in their home state.

HPEMT Awards $32,364,000 to Health Profession Schools

The award of $32,364,000 in federal grants to 103 schools of medicine, dentistry, and allied health professional institutions, has been announced by Dr. Leonard D. Fenninger, Director, Bureau of Health Professions Education and Manpower Training (HPEMT). The Bureau is a component of the National Institutes of Health, U. S. Department of Health, Education, and Welfare.

The funds were awarded under the health manpower legislation as "special improvement grants" which are intended to help schools strengthen their curricula, develop new courses, improve teaching methods, and otherwise increase the quality of their instruction. The grants are intended also to assist schools with serious financial problems to maintain their programs.

The awards have been distributed to 60 medical schools, 26 dental schools and 17 allied training schools, located in 38 states, the District of Columbia and Puerto Rico. They are divided into awards to schools which have not previously received special improvement grants and continuations to schools which have been represented in the program previously.

The University of Mississippi School of Medicine at Jackson was recipient of a new award, amounting to $287,148.

Competitive Athletics for Children—Guidelines Published

Medical societies who supply volunteer physicians and medical supervision to athletic events of local school systems should request from the AMA the statement on "Competitive Athletics for Children of Elementary School Age," published in October 1968 in *Pediatrics*.

Developed jointly by the American Academy of Pediatrics, the AMA Committee on the Medical Aspects of Sports, the American Association for Health, Physical Education and Recreation, and the Society of State Directors of Health, Physical Education and Recreation, the statement recognizes that because organized sports programs for children 13 years of age and younger are now widespread, medical and athletic directorial per-

sonnel should be aware of the special problems unique to these youngsters—"they are not miniature adults."

It states, "The problems involved are sufficiently significant and variable to warrant each community's having a local committee representing education, recreation and medical specialists." It recommends proper physical conditioning, guidelines for the conduct of the sport involved, grouping of the players in regard to their size, weight and skill, properly fitted equipment, well-maintained sports facilities, and delineation of the spheres of authority and responsibility for school administration, family, sponsor, physician, coach and athlete.

The statement concludes that "unless a school or community can provide exemplary supervision—medical and educational—it should not undertake a program of competitive sports, especially collision sports at the preadolescent level."

Grant Made for Health Care Study

Governor John Bell Williams has announced an Appalachian award of $50,000 to his Federal-State Programs Office to conduct a health care study in the twenty-county Mississippi Appalachian area during the summer and fall of this year.

The health survey is a cooperative project involving two of the Federal-State Programs, the Division of Appalachian Development and the Division of Comprehensive Health Planning, along with the University of Mississippi School of Medicine.

The University's Department of Preventive Medicine will conduct the survey under a contract with the Federal-State Programs Office.

David R. Bowen, Programs Coordinator, stated that the survey will inventory the health resources of the area and evaluate the needs for new and expanded health services and facilities.

"When this study is completed, Mississippi will be eligible to apply to the Appalachian Regional Commission for a demonstration health grant which may amount to several million dollars," added Bowen.

Governor Williams has nominated ten people from the Appalachian area to serve on a Technical Advisory Committee for the health care survey. They are: Dr. Paul Ellzey, Booneville, Dr. Emmett Black, Starkville, Dr. J. T. Davis, Corinth, Dr. W. M. Dickerson, Tupelo, Robert A. Ivy, Columbus, Julian W. Pigford, West Point, Cy Roberts, Nettleton, Mrs. Edna Roberts, Tupelo, R. L. Thompson, Corinth, Rep. Jerry Wilburn, Mantachie.

Dr. Rudyard Robison of Saltillo who was named earlier by Gov. Williams, as Mississippi's representative on the Appalachian Regional Commission Health Advisory Committee, will serve as consultant to the group.

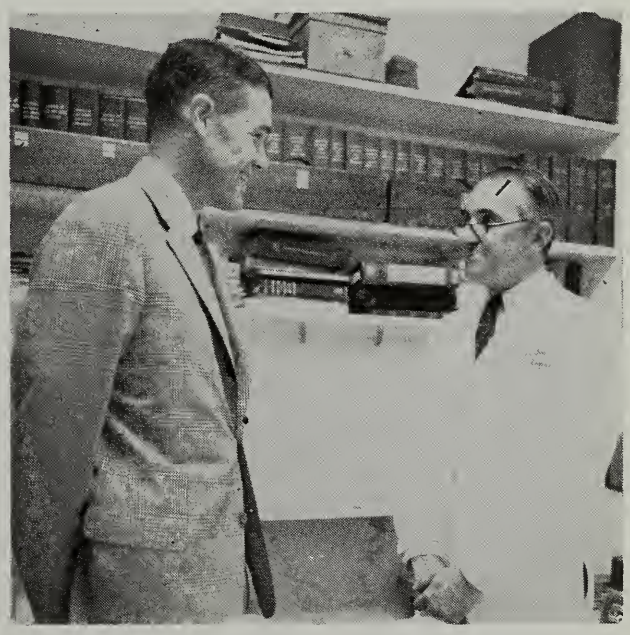
UMC Resident Works in Vietnam

University Medical Center orthopedic surgery resident Dr. Charles Turner left the States in mid-April to serve as an American Medical Association volunteer physician for South Vietnam.

A native Mississippian, Dr. Turner is the first UMC physician selected for the AMA program. He'll be based in Saigon on the two-month assignment and, through special cooperation of the Medical Center, complete his residency while there.

Dr. Turner holds the bachelor of science degree from the University of Southern Mississippi and received his M.D. at the Medical Center. He and his wife, the former Jackie Rogers of Collins, are the parents of three children.

Following his Vietnam tour, Dr. Turner will practice in Hattiesburg.



Dr. Charles Turner, at left, and Dr. Paul S. Derian, professor of surgery and chief of the Division of Orthopedics at the University Medical Center, discuss Dr. Turner's Vietnam trip.

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

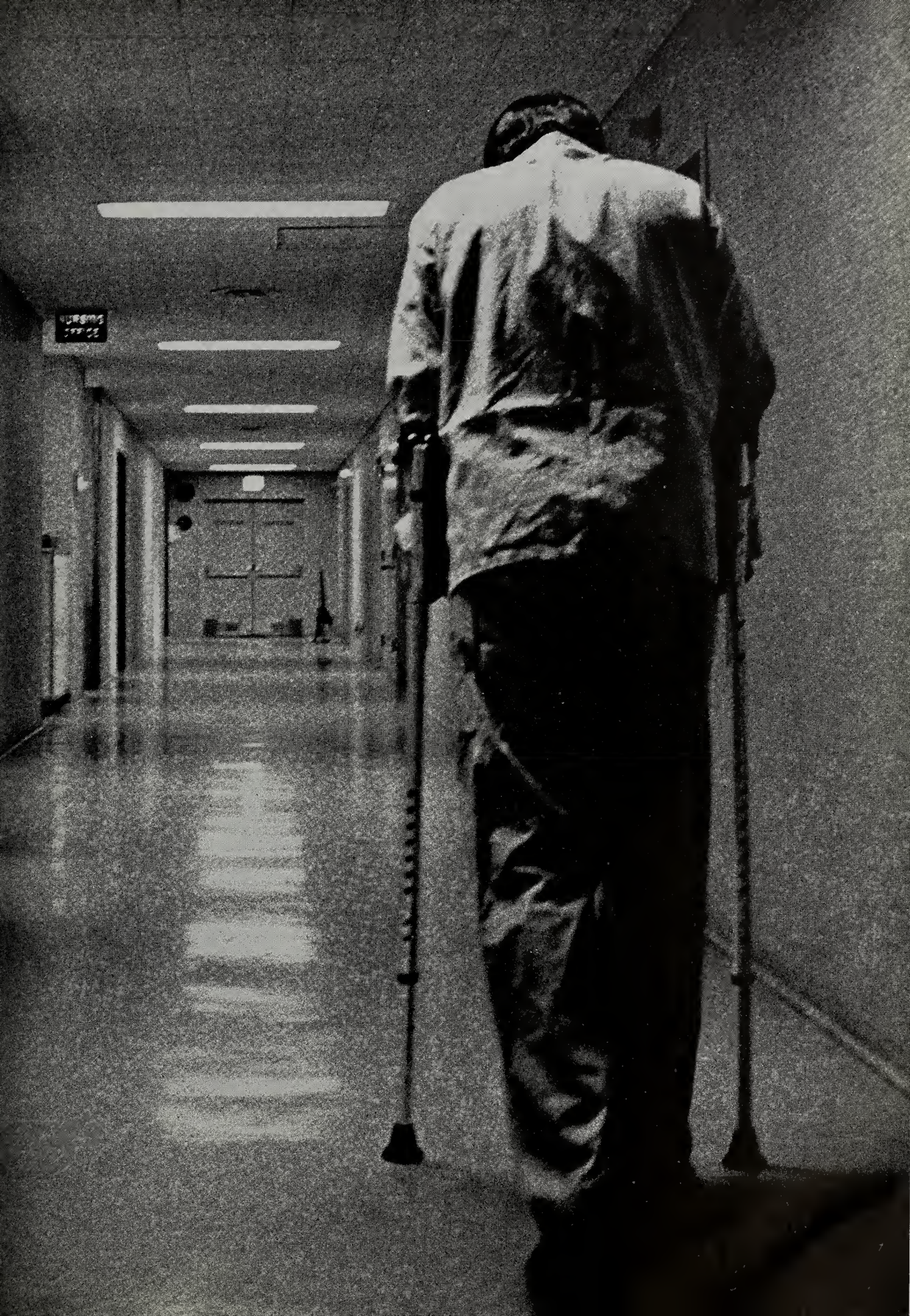
Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



UMC Medical Alumni Building Begun

Excavation began in late April on a $650,000 Medical Alumni Building at the University of Mississippi Medical Center.

The new building, which is scheduled for completion in January, 1970, will serve as a home and headquarters for the medical alumni and nursing alumnae chapters of The University of Mississippi Alumni Association. It will also be used by the General Alumni Association for many of their activities in the Jackson area. The Alumni Building will host some of UMC's post-graduate medical seminars and conferences.

The 20,000 square feet of floor space in the three-story structure occupies three acres between the existing north roadway and the curved driveway to the student apartments near Lakeland Drive.

The first floor will contain an attractive entrance lobby and registration area, a snack bar capable of seating 75 people, alumni offices, a meeting room with a seating capacity of 150, and a hostess apartment. On the second and third floors, overnight housing units will be available for the alumni, faculty and staff members and their relatives, families of students, officials of the State of Mississippi, official guests of the University, and registrants for programs in continuing education.

Architect for the construction is Larry Bouchillon and Jones and Thompson are general contractors.

12th Medical Progress Assembly Set for Sept.

The 12th annual Medical Progress Assembly is scheduled for Sept. 14-16, 1969 at the Parliament House in Birmingham, Ala.

The assembly, sponsored by the Birmingham Academy of Medicine, will feature such distinguished guest lecturers as Drs. Christiaan Barnard, Albert Sabin, Donald Harrison, Frances Ingersoll and Richard Blandau plus Mr. David Brinkley.

The 1969 program begins with a social hour at the Birmingham Museum of Art on Sunday, Sept. 14, followed by a banquet at the Birmingham Civic Auditorium for which the featured speaker will be NBC newscaster, David Brinkley.

Monday and Tuesday are devoted to scientific sessions featuring an outstanding faculty. Monday evening's program includes a social hour followed by a buffet dinner at Birmingham's Tutwiler Hotel at which Dr. Barnard will speak.

Fee for the assembly meeting is $30 which includes one ticket to Sunday evening banquet and Monday evening buffet dinner. Additional tickets may be purchased; for $10 to the Sunday banquet and $7.50 for the Dr. Barnard dinner.

For more information write to the 1969 Medical Progress Assembly, 1629 South 10th Avenue, Birmingham, Ala. 35205.



University Medical Center officials and Ole Miss medical and nursing alumnae representatives along with construction and architect principals broke ground in an early spring ceremony for the $650,000 UMC Alumni Building.

Mississippian Awarded Pfizer Medical Scholarship

Thomas L. Windham. 760 Lakeland. Jackson. Miss., has been awarded a $1.000 scholarship for the 1969-1970 school year by the University of Mississippi Medical Center. it was announced by Robert E. Carter, M.D., Dean.

A graduate of Southwestern at Memphis, Mr. Windham is a member of the class of 1969 at the University of Mississippi Medical Center. He was awarded the scholarship by school authorities on the basis of academic qualifications. Mr. Windham is married and the father of two children.

The scholarship was made available by the Pfizer Laboratories Division. which markets a wide range of ethical pharmaceutical products. A similar scholarship provided by the division is also available at all 99 medical schools in the United States.

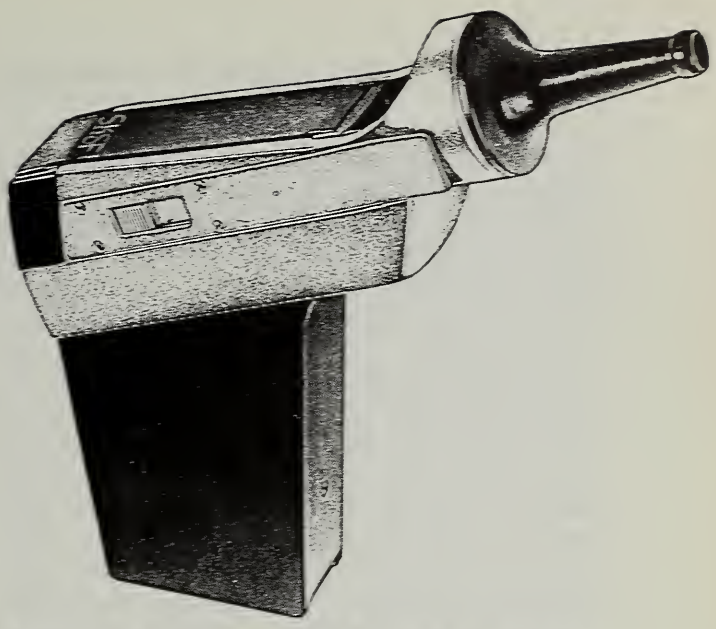
Physicians Attend Auto Crash Meeting

The AMA Committee on Medical Aspects of Automotive Safety drew approximately 50 physicians and automotive engineers to a two-day meeting this past May in Detroit to develop a standardized tissue damage scale for use in crash injury research studies.

The attendees. provided with copies of the various scales now in use for their evaluation. met in workshops. divided according to the medical specialties most involved with auto crash injuries. Among the areas in which scales were developed are orthopedics. abdominal injuries. chest injuries. facial trauma. ophthalmological and otolaryngological injuries. and general surgery.

Other specialty scales will be developed in the near future. with a target date for their use in an AMA-sponsored physician-police crash investigation project now being initiated. The first of the teams participating in this project will take an orientation course at the University of California —Los Angeles in mid-September.

Physicians from the western states area should write immediately for specifics to the AMA Committee on Medical Aspects of Automotive Safety. 535 North Dearborn Street. Chicago. Ill. 60610.



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A revolutionary new instrument rather than an improvement over existing equipment, the Hotchkiss Otoscope employs the principles of modern optics to give you a brighter, clearer, more informative view of the ear canal and tympanic membrane. It's also more versatile than ordinary otoscopes—you can use it for diagnostic or operative procedures without making any changes. Yet the five-ounce Hotchkiss is lighter, easier to handle and carry, and every bit as durable as instruments that offer you less.

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I would like your Representative to call for an appointment to show me the new Hotchkiss Otoscope.

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City _____ State _____ Zip _____

meeting at least three months prior to the annual session at which the elections will occur, and to publish a slate of nominees to the membership at least one month prior to the annual session. This action was taken by amendment of Section 2, Chapter VI, of the By-Laws. Previously, nominations were made at the annual session.

Committee Work. The Nominating Committee is due the deep appreciation of all members. A meeting was conducted early in 1969, and difficulties in the new procedures were immediately apparent. The eligibility criteria, two years membership and attendance upon two-thirds of the past two and present annual sessions, were a major problem. Many desirable nominees had attended only one of the past two annual sessions, so nomination of such members is contingent upon attendance at the present meeting.

The committee chose a slate, and the Executive Secretary wrote all 69 nominees as to acceptance. Many declined, and the committee was required to conduct a second meeting. The slate, published in the April JOURNAL, still carries many "contingent" nominees, as the report states. It will be necessary for the committee to meet a third time during the annual session.

Members of the committee worked diligently, devoting much time and effort to communicating with the membership through component medical societies and by personal contact. The committee reported these difficulties to the Board, but it carried out its duties with commendable spirit in view of the difficulties.

Action of the Board. While the ideals sought in the new procedure have merit, the practical difficulties inherent in it are such that the procedure is virtually unworkable. This has been demonstrated in that the committee has traveled to meetings at Jackson twice and will conduct a third meeting here. Staff work formerly accomplished on nominations in hours took several days. A firm slate is still to be achieved.

The Board of Trustees, therefore, recommends that Section 2, Chapter VI, of the By-Laws be repealed and the version previously in use for many years to be re-adopted. This is the version contained in the Constitution and By-Laws published in 1967 and preceding years.

We commend the spirit of leadership selection as visualized in the unsuccessful experiment to all members of the association, earnestly asking that each among us participate seriously in the selection of qualified, willing nominees in the interest of our association.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

At the 100th Annual Session, Section 2, Chapter VI, of the By-Laws was amended to provide for a new nominating procedure. Under this change, the Nominating Committee is chosen one year in advance and is obliged to meet three months prior to the annual session for the purpose of naming a slate of nominees which shall be published to the membership not less than one month prior to the annual session at which elections are to take place.

The new procedure was instituted in 1968-69 and, as reported to this House of Delegates by the Board of Trustees, was unsuccessful and most difficult to accomplish. The Board has recommended that this procedure be repealed and the former nominating procedure be re-instituted.

Your council therefore recommends that Section 2, Chapter VI, of the By-Laws be repealed and the following substituted therefor: "Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each public health district. Five members shall be nominated for a vacancy occurring on the Board of Trustees of Mental Institutions which nominations shall be submitted to the Governor in accordance with law."

The report of the council, acting as a reference committee, was adopted.

SUPPLEMENTAL REPORT "I" OF THE BOARD OF TRUSTEES

Past Actions. This is the sixth consecutive year in which the issue of Blue Shield in Mississippi shall have been the subject of formal action by the House of Delegates. In summary review, the Board of Trustees held to a conservative position

through 1966, requesting that the House of Delegates grant it a year in which to continue conference and negotiation with the plan in a sincere effort to resolve difficulties. In 1967, the Board reported that it was not satisfied with progress realized, despite diligent and sincere effort and recommended that the House authorize withdrawal of association approval of the plan if improvements were not forthcoming. The House approved the recommendation, even authorizing the Board to apply for a charter and use of the Blue Shield symbol in establishing a plan under association aegis and sponsorship.

1967-1968 Actions. In pursuance of further effort to resolve differences, the Board of Trustees sought and received the advice of the National Association of Blue Shield Plans, and the Board accepted a compromise proposal consisting of six points:

(1) Effect a definitive separation of Blue Cross and Blue Shield in Mississippi by having separate corporations for each.

(2) Separate boards of directors for Blue Cross and Blue Shield, with the state medical association participating in the election of Blue Shield directors.

(3) Separation of Blue Cross and Blue Shield funds, which means two separate treasuries, with each plan self-sustaining.

(4) Separate Blue Cross and Blue Shield contracts or a single contract with Blue Cross and Blue Shield benefits and dues (premiums) separately and distinctly identified.

(5) In view of capable management and a high level of staff people in the present plan, give consideration to having a single management who reports to the two separate boards of directors.

(6) Development of Blue Shield benefits on the usual and customary fee basis with the close cooperation of the state medical association, using the resources of the association in a consultant capacity.

The Board conducted extensive conferences and negotiations with representatives of NABSP and the plan during 1967. On March 27, 1968, the plan rejected the proposal for separate Cross and Shield corporations and separate boards of directors. Having no further alternatives to explore within the framework of policies and objectives adopted by the House of Delegates, the Board acted to withdraw association approval of the Mississippi Hospital and Medical Service, Inc., as a Blue Shield plan, and the National Association of Blue Shield Plans voted "that the membership of the Mississippi Hospital and Medical Service be placed on a conditional basis pending an investigation by the NABSP Board of Directors."

The Board reported its action to the House of Delegates at the 100th Annual Session in 1968, emphasizing the fact that it did *not* make the decision to apply for a charter and use of the Blue Shield symbol. The House of Delegates endorsed this action overwhelmingly with only a single recorded dissenting vote.

Subsequent to the annual session, the Board conducted further conferences and negotiations, including representation before the Board of Directors of NABSP. At all times, as stated in its 1968 report, the Board of Trustees has stood ready to confer with the plan. On many occasions, the open-door policy has been reiterated. There have been conferences with the plan, and the invitation for continuing communication is standing.

Decisions of Blue Plan. On April 8, 1969, the plan communicated formally with the Board of Trustees, submitting a report of various organizational and policy decisions and furnishing the association with a financial statement as of Dec. 31, 1968, and Jan. 31, 1969.

The plan reported a reorganization of its Board of Directors under which it will be reduced to 18 members in three years from the present 36 members. The proportion of representation, i.e., one-third physicians, one-third hospital representatives, and one-third public is unchanged.

The plan has also acted to limit the tenure of board members to a maximum of three consecutive terms of three years each with terms expiring on or after March 1970. The tenures of the chairman and vice chairman of the board are limited to five years each. Other internal organizational innovations with reference to nomination of directors and committee structures are being made.

Finally, the plan's board has adopted a resolution seeking a recision of the association's action in withdrawing approval of the Mississippi Hospital and Medical Service, Inc., as a Blue Shield plan.

Report of Plan. The plan reports that it expects "to refine our accounting procedures . . . and eventually show the separation of each (Cross and Shield) in the detailed items which have been left blank in our January statement." Progress toward this goal has been reported. The plan also reports that its marketing efforts have been aimed at upgrading benefits in Shield coverage. As of January 1969, the upgrading left 45 per cent of contracts with fourth day medical coverage or less and about 49 per cent of contracts with surgical schedules below $225.

Action by NABSP. Under NABSP by-laws, an investigation period of a Blue Shield plan from which medical association approval has been withdrawn may extend up to two years. This period permits conference, negotiation, and accommodation efforts. At the time of our association's action, membership of a Blue Shield plan required approval of a majority of physicians in the plan area.

At the April 10-13, 1969, meeting of the NABSP Board of Directors, this approval criterion was changed, and the following requirement for plan approval was adopted: "A Plan shall have substantial support of the medical profession, evidence of which shall be approval of the Plan by the appropriate medical society or societies."

Recommendation of the Board. The Board of Trustees recommends no alteration of association policy with reference to Blue Shield, which policy was developed over four years with the approval and endorsement of the House of Delegates. The Board recommends no further action at this time with reference to the withdrawal of approval. The Board continues to stand ready under its open-door policy to confer and negotiate with the plan, recognizing that some progress is being made toward the six goals adopted by the House of Delegates. The Board continues to believe that these goals should be pursued by the plan and that Blue Shield coverage and benefits in Mississippi eventually be raised to those levels of the best plans in the nation.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

For the sixth consecutive year, the issue of Blue Shield is before the House of Delegates of our association for official action. The Board has reviewed the succession of events which led to the association's having withdrawn its approval from the Mississippi Hospital & Medical Service as a Blue Shield Plan. The National Association of Blue Shield Plans, under its By-Laws, voted to place the Mississippi Plan on conditional membership pending investigation by the NABSP Board of Directors.

The Board of Trustees has maintained an open-door policy offering itself for conference and negotiation with the Plan. The Board notes that some progress has been made with reference to the six points which this House of Delegates previously adopted. At the 100th Annual Session in 1968, the Board of Trustees reported its having withdrawn approval of the Plan as authorized by the House and the Board also reported that it did *not* make the decision to apply for a charter and use of the Blue Shield symbol in Mississippi. This action was overwhelmingly endorsed by the House of Delegates with only a single recorded dissenting vote.

During the 1968-69 association year, the Board conducted further conferences and negotiations including representation before the Board of Directors of NABSP and the Board of Directors of the Mississippi Hospital & Medical Service. On many occasions, our Board of Trustees has reiterated the open-door policy and it is our understanding that the invitation for conference and negotiation remains open.

The Board has recommended no alteration in association policy with reference to Blue Shield which policy was developed over a period of four years and approved by this House of Delegates. The Board has also recommended that no further action be taken at this time with reference to the withdrawal of approval by the association of the Plan. The Board continues to stand ready to negotiate with the plan at any time in an effort to assist in reaching the six goals outlined and approved by the House of Delegates.

Your reference committee fully concurs and endorses the report of the Board of Trustees in this connection and recommends its adoption.

The report of the reference committee was adopted.

REPORT OF THE SECRETARY-TREASURER

Dr. Walter H. Simmons: Duties and Responsibilities. As an elected general officer of the association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee as chairman of the Council on Scientific Assembly and member *ex officio* of councils and committees.

Membership. Although little change was reported in membership for 1968 over 1967, there is an encouraging upward trend for 1969. Totals for the entire calendar year of 1968, as of Dec. 31, are:

1,270 paid Active members
60 Emeritus members
49 members exempt from dues other than Emeritus

This is a total of 1,379 for the year 1968. During the first four months of 1969, our membership has totaled 1,398, reflecting a notable increase.

Totals as of April 30 are:

1,289 paid Active members
66 Emeritus members
43 members exempt from dues other than Emeritus

Paid Active AMA dues for 1969 already exceeds 1968 with a total of 1,264 against 1,261 for the entire year of 1968.

MISSISSIPPI STATE MEDICAL ASSOCIATION
CONDENSED STATEMENT OF
FINANCIAL CONDITION
APRIL 30, 1969

ASSETS

Current Assets		
General Fund		
Cash on deposit	$141,210.92	$
Due from Department of Defense, CHAMPUS administrative costs	3,227.75	
Due from JOURNAL advertisers	7,135.59	
Other receivables	421.40	
Prepaid expenses	1,128.46	153,124.12
CHAMPUS Professional Fund		
Cash on deposit	26,391.29	
Due from Department of Defense	73,608.71	100,000.00
Fixed Assets		
Building and equipment, less depreciation	68,590.85	
Land	13,605.30	82,196.15
Other Assets		
Deferred CHAMPUS expenses	1,534.36	
Refundable deposit (utilities)	25.00	
Building addition plans and engineering	4,935.00	6,494.36
Total book assets		$341,814.63

LIABILITIES AND NET WORTH

Current Liabilities		
AMA dues attached by court order	$ 29,400.00	$
Amortization, building, current year	5,566.80	
CHAMPUS capitalization	100,000.00	134,966.80
Long Term Liabilities		
Building	8,298.41	8,298.41
Net Worth		
Unappropriated net worth		198,549.42
Total liabilities and net worth		$341,814.63

Court Action. A writ of attachment arising out of a civil suit filed in Forrest County has been served against AMA dues of Mississippi physicians in the transit process. This involves 420 physicians and a total amount of $29,400.00. Defendants named in the suit are the American Medical Association, the Mississippi State Medical Association, the South Mississippi Medical Society, two officers of the South Mississippi Medical Society as individuals, and the Executive Secretary of the state medical association, also named as an individual defendant.

The association has taken appropriate measures to protect the AMA membership of those physicians whose dues are attached by the suit. All have been placed in good standing for 1969 without interruption in the continuity of their respective membership records on the certification of our association.

Fiscal Reporting. In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's fiscal condition as of April 30, 1969, as an attachment to this report. The Council on Budget and Finance has reviewed the fiscal records, report of audit, and has reported to the Board of Trustees in this connection. An overall budget of $190,217.00 has been recommended to and approved by the Board of Trustees, and a copy of the budget is attached to this report. This amount is exclusive of funds which the association will expend in payment of professional fees and for other services under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which will be reimbursed to the association by the Department of Defense. For this purpose, we hold an interest-free capitalization of $100,000.00 as shown in the financial statement.

Constitutional Duties. Your Secretary-Treasurer, as an *ex officio* member of councils and committees, meets with various official bodies of the association and sits with the Board of Trustees as a general officer. Activities related to service as chairman of the Council on Scientific Assembly have been reported separately.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Report of the Secretary-Treasurer. Your reference committee is indeed gratified to see the encouraging upward trend in membership which was reported to us by the Secretary-Treasurer, Dr. Walter H. Simmons of Jackson. We note in his report information with reference to a civil suit filed in Forrest County against the American Medical Association, the Mississippi State Medical Association, the South Mississippi Medical Society, two officers of that component medical society and our Executive Secretary. Your reference committee wishes to inform the House of Delegates that the bill of complaint as filed by the plaintiff is available for any member of the association to read in the convention office and thereafter in the executive offices of the association in Jackson.

We thank Dr. Simmons for his splendid report and for his work as Secretary-Treasurer and recommend adoption of his report.

The chairman of the reference committee moved adoption of the report. In discussion, Dr. J. P. Culpepper, Jr., of Hattiesburg, desired to make a statement, and he was recognized by the chair. He said that he had been a member of the state medical association for 45 years and a member of the House of Delegates for 35 years.

In 1963, Dr. Culpepper said, he was serving as Delegate to the American Medical Association, as Vice President of AMA, and as a Trustee of AMA. He stated that he sustained injuries during a trip to Alaska which he made on official invitation. He said that he had appeared since that time before the AMA Board of Trustees, requesting help because of inability to practice. The AMA Board did not respond, he continued, and the matter was placed in the hands of attorneys.

There being no further discussion, the chair put the motion, and the report of the reference committee was adopted.

REPORT OF THE COUNCIL ON BUDGET AND FINANCE

Report of the Secretary-Treasurer. We have considered the fiscal portion of the Report of the Secretary-Treasurer and we have examined the operation of the association with respect to all fiscal activities including the report of the independent certified public accountant. The findings are to the satisfaction of your council. Prior to this annual session, and during the annual session, we have met for these purposes and have conferred with the Board of Trustees. We have determined that all accounts, receipts and disbursements are regular, proper and authorized.

Association Budget. We have considered the 1969-70 budget for operation of your association and we have conferred with the Board of Trustees who have approved our recommendations. Each item in the budget has been carefully evaluated as to necessity and adequacy. We recommend the total budget of $190,217.00, which includes the following sums for the purposes stated: (1) For general operation of all activities and departments of the association, including production of your JOURNAL, $137,548.33; (2) Building, amortization, utilities, maintenance, taxes, and associated expenditures for the building, $12,346.89. The budget also includes the sum of $12,500.00 for the conduct of the present annual session and the remainder is for reserves and contingent funds. The overall budget is exclusive of professional fee aspects of the CHAMPUS Program which is reimbursed to the association by the Department of Defense. We hold, for the purpose of administering this program, an interest-free capitalization of $100,000.00. We recommend adoption of the budget as being a realistic minimum for the continued effective operation of your association.

Insurance and Safeguards. We have examined a survey of insurance owned by the association on its properties and against certain liabilities which conceivably could be incurred and find it adequate. Suitable safeguards for disbursement procedures, the handling of incoming funds, and proper safeguarding of records have been provided and each has been examined by your council. We find these to be adequate and sufficient for our needs.

Dues of the Association. Your Mississippi State Medical Association dues have been increased only on one occasion in the past 15 years, and this increase was from $50 per year to $60 per year. Most state medical associations levy substantially greater dues on their membership than our association. Your council points out that the continuing spiral of inflation, the mounting costs of doing business, the building program, increased services to the membership, and the responsibilities which the association is expected to meet in behalf of its membership are such that stable funding in increased amounts is needed.

Your Council on Budget and Finance has informed the Board of Trustees that membership dues should be increased and we take this opportunity to inform the association through the House of Delegates that such a proposal will be made at the 102nd Annual Session in 1970. We ask that the House receive this portion of the report for information.

The report of the council was adopted.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Rowland B. Kennedy: Duties and Responsibilities. Your Executive Secretary is responsible for maintaining the headquarters office, for conducting the administrative affairs of the association, and for various fiduciary duties as required by Article VII of the Constitution and Section 7, Chapter VII, of the By-Laws. During the 1968-69 association year, your Executive Secretary submitted approximately 60 written reports to the Board of Trustees and general officers. Because of this frequent and detailed reporting, this report is purposely brief and limited in scope.

Resignation of Executive. Effective April 15, 1969, our valued and able Associate Executive Secretary, Mr. Charles L. Mathews, resigned his post after nine years service to your association.

The resignation leaves a gap in staff capabilities which will be difficult to fill. Your Executive Secretary requests that the House of Delegates join him in wishing Mr. Mathews every success in his new endeavors and to commend him for his many and substantial contributions to your association.

Executive Staff. With continuing growth of association activities and programs, additions have been made to the executive staff. During the year, the average was 15 members, although at the time of preparation of this report, we are 13 in number. The Board of Trustees is conversant with staffing needs, and the Board has acted promptly where necessary and justified in this respect. Generally, we continue to be successful in recruiting personnel with good qualification and specialized skills. We also conduct good training programs.

We are especially grateful for the Board's having provided excellent facilities and equipment. The building expansion, twice approved by the House of Delegates and implemented by the Board of Trustees, is an urgent necessity. Your building was 13 years old this month, and experience has shown it to be a wise and prudent investment.

The staff is grateful for the close *rapport* it enjoys with the Board of Trustees, general officers, and the component medical societies. We appreciate the opportunity in sharing some small part in the successes of your association, and we pledge our continuing best effort in your behalf.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the Report of the Executive Secretary and notes that he has made approximately 60 written reports to the officers, trustees and various councils of the association during the year. Your reference committee especially congratulates the staff including the *fine young ladies* who work for the association and express our appreciation for their services. We recommend adoption of the Executive Secretary's report.

The report of the reference committee was adopted.

REPORT OF THE DELEGATES TO AMA

Reporting Format. Your Delegates to the American Medical Association continue to limit their report to this House of Delegates to policy actions at AMA level because of the continued excellent reporting in the *AMA News* and *Journal AMA* of scientific and subsidiary activities of the annual and clinical conventions. This report is concerned with the San Francisco and Miami Beach conventions conducted in 1968. There were no special or called meetings of the House of Delegates during the year.

Dr. G. Swink Hicks of Natchez was seated for the first time at the San Francisco annual convention. Both of your regularly elected Delegates, Dr. Hicks and the incumbent senior Delegate, Dr. Howard A. Nelson of Greenwood, attended and participated in each convention. We are grateful that our President, President-elect, a Trustee, and many members have been in attendance upon these conventions. We note also with pride participation by a number of Mississippi physicians in the Scientific Assembly and the fact that Dr. William E. Lotterhos of Jackson serves as a member of that AMA council.

San Francisco Annual Convention. The 117th Annual Convention was conducted June 16-20, and the House of Delegates was in session four days considering 143 items of business, including 84 resolutions, 39 reports of the Board of Trustees, and the remainder from councils.

Major issues before the House included elimination of discrimination in membership, health care costs and financing, governmental relations, health manpower, medical education, infant mortality, transplantation of human tissue, and the financial status of AMA.

A strong and punitive resolution sponsored by the Massachusetts delegation called for amendment of the By-Laws to provide avenues of appeal for physicians "who allege that they, because of color, creed, race, religion, or ethnic origin, have been unfairly denied membership in a component and/or constituent association." The resolution provides that the Judicial Council, upon determining that the allegations are indeed true, may admonish or censure the component or constituent (state) association. In case of repeated violations, the Council may recommend to the House of Delegates that the state association involved be declared to be no longer a constituent association of the AMA.

An array of related actions were concerned with care costs and financing. Support of voluntary prepayment and health insurance was reaffirmed, and the concept of tax credits for medical care expenditures, including premiums for insurance, was recommended. The House called for placing care costs in true perspectives and for maximum effective utilization of health manpower and facilities.

Comprehensive health planning participation by physicians and societies was encouraged, and

the House warned against accrual of such activities and prerogatives to state and federal agencies of government. A new Council on Health Manpower was created as a council of the Board of Trustees, and it was reported that negotiations between medicine and osteopathy have been rendered difficult "in the absence of cooperative leadership."

State associations were urged to continue and intensify support of medical education and medical schools, and essentials of approved residencies in general practice, physical medicine and rehabilitation, psychiatry, and anesthesiology were revised.

A new policy statement on infant mortality urges medical concern over environmental conditions, health education, and broad and inclusive care of unwed mothers. A report of the Judicial Council stating that "when a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician . . ." was approved.

The House was informed that "fiscal uncertainties" lie ahead for AMA, and the report of the Board of Trustees stated that "a substantial increase in the budget of the AMA will be necessary within the next few years. . . ." Additionally, AMA will, beginning with the tax year 1968, pay taxes on approximately $13 million advertising income. A number of organization changes related to terms of office and structure of the Scientific Assembly were approved.

An unpleasant interruption in the House of Delegates by representatives of the Medical Committee on Human Rights occurred at the opening session of the House of Delegates.

Miami Beach Clinical Convention. The major action at the Dec. 1-4 clinical convention was amendment of the By-Laws providing appeal avenues for those applicants for membership alleging discrimination and for providing a constitutional means for expulsion of a state medical association found in repeated violation of such discrimination. The amendment was narrowly adopted by a margin of only three votes.

Ninety-four items of business, including 62 resolutions and 22 reports of the Board of Trustees, were considered. Subject areas paralleled closely those of the San Francisco annual convention. Further definitive actions were taken on the absorption of osteopathy into medicine with special recommendation for strengthening the curricula of schools of osteopathy toward the end of upgrading them to medical schools eligible for AMA accreditation.

President Dwight L. Wilbur urged a five-point program in his presidential address, calling for high quality medical care for all Americans at the most reasonable possible cost, putting a rein on care costs by careful and diligent utilization of hospitals, developing more reasonable and more realistic expectations by the public, unifying the profession and maintaining constructive liaison with other groups, and planning for an orderly and enhanced future for medicine. The House again urged enactment of tax credits for the purchase of health insurance and asked that AMA vigorously promote such a federal enactment. Impetus will be given to care cost studies under another House action.

Recognizing that advertising and promotion of new Blue Shield programs providing broader benefits might be subject to misinterpretation by the public, the House resolved that "any reference to paid-in-full coverage clearly identify those services which indeed are covered on a paid-in-full basis and also identify the circumstances under which those services must be rendered."

The policy statement on transplantation of human tissue and the ethical implications inherent in such procedures were amplified by the Judicial Council. The action asked that the evolution of the therapy be orderly and that any major medical center undertaking such procedures be fully prepared by training, research, and experience in immunosuppressive therapy to do so.

The House agreed that there is need for physician prescription and supervision of all ancillary services provided in the hospital. The policy states that "the medical staff should concern inself with contractual agreements between various allied health professionals and the hospital only insofar as, and to the extent that, such agreements tended to remove the provision of ancillary services from the prescription and supervision of the physician."

Other actions urged AMA to seek to have the Congress phase out federal health care programs which overlap and duplicate Title XIX Medicaid and to amend the Comprehensive Health Planning Act to permit "a substantial percentage" of planning boards and councils to be practicing physicians.

AMA was asked to provide leadership in sponsoring public affairs workshops for the benefit of state and component society leaders, and the House resolved to "exert every effort to bring about the elimination of unnecessary documentation of medical services by the physician, hospital, and fiscal intermediary on Medicare and Medicaid patients."

Dr. F. J. L. "Bing" Blasingame, former Execu-

tive Vice President, addressed the House calling for a constitutional convention to re-evaluate the working of the AMA and to equip it better for the Herculean tasks it faces. His remarks were statesmanlike, serious, and forwardlooking. Three resolutions commending his service as a Delegate, Trustee, and Executive Vice President were adopted.

Expression of Delegates. Your Delegates to AMA express their appreciation to the state medical association's Board of Trustees and general officers for support and the maintenance of continuing communication in the guidance of our representation. We sit with the Board at all meetings, and we are thereby enabled to be fully informed on association policy and positions. We pledge our continued best effort in representing the desires, wishes, and policies of the association in the AMA House of Delegates.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee appreciates the report of the Delegates to the American Medical Association, Dr. Howard A. Nelson of Greenwood and Dr. G. Swink Hicks of Natchez. We express our appreciation for the splendid representation which they have made in our behalf in the House of Delegates of the American Medical Association and we recommend adoption of their report.

The report of the reference committee was adopted.

REPORT OF THE NOMINATING COMMITTEE

The Nominating Committee was selected at the 100th Annual Session, May 13-16, 1968, at Jackson, under the revised By-Laws. Of the original committee, seven served at the 101st Annual Session. Replacement appointments were made in the instances of the death of Dr. E. LeRoy Wilkins of Clarksdale (District 1) and of the resignation of Dr. B. B. O'Mara of Biloxi (District 9):

James T. Thompson, Moss Point, District 9, Chairman
John G. Egger, Drew, District 1
James O. Gilmore, Oxford, District 2
Thomas W. Wesson, Tupelo, District 3
S. Lamar Bailey, Kosciusko, District 4
J. A. K. Birchett, Vicksburg, District 5
Charles B. Mitchell, Jr., Meridian, District 6
C. R. Jenkins, Laurel, District 7
W. M. Dabney, Crystal Springs, District 8

The committee met on two occasions three months prior to the annual session and published its slate of nominees in the April 1969 JOURNAL. An open meeting was conducted on May 15, 1969, to replace nominees who, by reason of failure to attend the 101st Annual Session, became ineligible. Both reports were presented to the House of Delegates, and there were no nominations from the floor.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates. It is charged with the responsibility of planning the annual sessions of the association to include all scientific activity and the programming and scheduling of annual session events. The council membership consists of the chairmen and secretaries of the several scientific sections and the secretary-treasurer of the association.

101st Annual Session. Your council began planning for this 101st Annual Session of the association at a meeting in Biloxi last Augst, 1968. The council has sought to continue a general scientific format in the context of meeting by specialty sections. Additionally the council has requested and placed scientific speakers on the several specialty sections from specialty societies not represented on the council.

The council is happy to report that twelve specialty society groups will be meeting during this 101st Annual Session. Additionally, medical alumni groups of four medical schools will be conducting functions. The council continues to emphasize that this combination of meetings benefits all groups as they compete for the time and attention of the busy practitioner.

Your council has again this year scheduled film programs preceeding each of the scientific sections. The council believes that a variation in programming and format for our scientific sessions is important in establishing and continuing good attendance at the sessions and in this connection, your council will be viewing the feasibility of conducting special scientific seminars and round table scientific seminars at future annual meetings of the association.

Your council has also acted to continue sponsorship of the annual "Aesculapius Award for Scientific Achievement" given to that member of the association presenting the most outstanding scientific exhibit. From 1966 through 1968, this award was sponsored by Mead Johnson Laboratories. There has been an increase in both the quantity and quality of scientific exhibits since inception of the award.

Expression of the Council. Your council is

deeply grateful for the support, assistance, and cooperation which we have received in planning the 101st Annual Session. We hope that this meeting will be professionally profitable and personally enjoyable to all.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee approves the Report of the Council on Scientific Assembly and asks that the House of Delegates associate itself with us in commending all fifteen members of the council for the splendid program which has been ours to enjoy.

The report of the reference committee was adopted.

REPORT OF THE COMMITTEE ON AMA-ERF

Organization and Duties. Your Committee on AMA-ERF is composed of one member from each component medical society appointed annually by the president of our association. The committee works in conjunction with the American Medical Association—Education and Research Foundation and solicits voluntary contributions from Mississippi physicians for medical education and research. All contributions are tax deductible and every dollar received is put to work in a medical school of the donor's choice or in medical research.

1968 Contributions. Your committee is happy to report that Mississippi physicians contributed $9,410.17 to AMA-ERF during 1968. Our University of Mississippi School of Medicine's AMA-ERF allocation for 1968 is $12,099.97. Over 80 per cent of this amount represents contributions from Mississippi physicians; the remainder is the University's share of undesignated contributions.

1969 Program. Your committee earnestly solicits a contribution to AMA-ERF from every Mississippi physician in 1969. We commend to you the policy of a number of the association's component medical societies to devote a portion of one society meeting each year to an appeal for AMA-ERF contributions.

Presentation of UMC Contributions. At this time I ask the Dean of our University of Mississippi School of Medicine to come forward and accept on behalf of the medical school its 1968 AMA-ERF contribution, a check in the amount of $12,099.97.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

We are gratified to note that voluntary contributions from Mississippi physicians and the Auxiliary members to AMA-ERF notably increased during 1968. We were therefore able to present the University of Mississippi School of Medicine with a check for $12,100.00. In approving this resolution, we urge that every member of the association and every Auxiliary member participate in this meritorious program of private and voluntary support of medical education.

The chairman of the reference committee moved adoption of the report. In discussion, Dr. C. D. Taylor, Jr., stated that $28.93 had been contributed to AMA-ERF during the annual association party on May 14, 1969. The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties. The Council on Medical Service is a constitutional body of the House of Delegates. It is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under its jurisdiction there are assigned the activities of the association in Medical service, emergency service programs, indigent care and allied medical agencies. The council is assisted in its work by three constitutional and three ad hoc committees. Programs, studies, and activities of the council's several committees embraced a wide range of subject areas and policy development during the 1968-69 association year.

Committee on Maternal and Child Care. The committee has continued its study and evaluation of maternal deaths occurring in Mississippi. As of March, 1969, the committee had sent out 563 inquiries on maternal deaths since its study began in January, 1958. Replies to these inquiries continue to occur in 83 per cent of the cases. The committee's IBM study program of the maternal deaths reviewed by the committee has continued to the point where a special scientific paper entitled "Cause and Treatment of Maternal Mortality Due to Hemorrhage—A Ten Year Study" will be presented on the scientific program at the association's 101st Annual Session. In the near future the committee will present other major scientific papers developed from its IBM study data on maternal deaths. A scientific exhibit is also being considered by the committee for presentation in this connection.

Following up on the committee's report to the House of Delegates last year concerning the development and publication of a set of "Maternal Health Desk Cards" for distribution to hospitals in the state, the committee wishes to report that a card booklet was sent to each hospital chief-of-staff in the state during the past summer with a cover letter explaining the cards

and a reorder form. Based upon an initial mailing of 136 sets of the cards, the committee received requests for an additional 323 sets from hospitals throughout the state.

Committee on Mental Health. This committee has responsibility in the broad field of mental health activities. During the past year members of the committee have met with public and private agencies whose programs are concerned with mental health activities. The chairman of the committee officially represented the association at the 15th Annual Conference of State Medical Association Mental Health Committees, sponsored by the AMA, March 14-15, 1969.

Committee on Occupational Health. This committee has responsibility for studying all aspects of occupational health in Mississippi. As a follow-up to its "Study of Occupational Health Programs in Small Plants in Mississippi" presented to the House of Delegates in 1967 the committee has reported that it will develop a guide for occupational health programs in small plants in Mississippi.

The committee has continued publication of a series of articles in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concerning various subjects in the field of occupational health and in this connection the second article in the series titled "Responsibilities of the Physician in Workmen's Compensation Cases" appeared in the May 1968 issue of the JOURNAL. The committee also reports that a legislative goal of the committee and the association to include occupational disease coverage in the Mississippi Workmen's Compensation Act was accomplished during the 1968 Regular Session of the Mississippi Legislature with amendment of the act for this purpose.

Committee on Nursing (ad hoc). This committee has responsibility for conducting a program of active liaison with the Mississippi Nurses Association. During the 1968-69 association year the committee has met with its counterpart from the Mississippi Nurses Association for discussion of three topics of interest and concern to the two professions. They are: (1) Accreditation of New Nursing Schools in Mississippi; (2) Clinical Training for Nurses and Coordination of Nursing Training in Mississippi; and (3) Mandatory Licensure for R.N.s and L.P.N.s in Mississippi. The committee's recommendations with respect to the subjects of accreditation and mandatory licensure will require policy actions by the House of Delegates and therefore will be covered in a special supplemental report to the House of Delegates. In regard to the subject of training for nurses, the committee recommends that the association encourage hospitals in the state to establish formal inservice training programs for new R.N.s and L.P.N.s.

The committee also reports that a nursing education advisory group has been named by the Board of Trustees of Institutions of Higher Learning and that the chairman of the committee serves with this group.

Health Insurance Benefits Advisory Committee (ad hoc). This committee was established by the council to act as a fact-finding and advisory committee on operation of the Medicare Program in Mississippi. The committee also serves as an advisory committee to the Medicare Unit of the Mississippi State Board of Health and during the 1968-69 association year the committee has met with representatives of this agency and the Travelers Insurance Company and other fiscal contractors for Medicare in Mississippi. The committee has served to bring physicians' inquiries concerning professional fee allowances under Medicare to the attention of the Medicare fiscal contractor for professional services—the Travelers Insurance Company. Each inquiry has been handled with dispatch and courtesy by Travelers' representatives and the committee expresses its appreciation for this. In turn the committee has offered professional advice to Travelers' representatives upon request.

In its role as professional advisory committee to the Medicare Unit, Mississippi State Board of Health, the committee has reviewed certain professional aspects of utilization review in extended care facilities. The committee proposes that this subject area be the object of a series of meetings sponsored by the Mississippi State Board of Health and this proposal will be covered in a supplemental report to the House of Delegates.

Committee on Blood and Blood Banking (ad hoc). This committee continues to monitor all aspects of blood banking and transfusion service, blood products, and professional and socioeconomic policy in this connection. During the 1968-69 association year the committee has been particularly concerned with problems of donor recruitment and blood replacement and the need for both public and professional education concerning this subject area. The committee formulated a program on this subject which was presented at a recent meeting of the Central Medical Society. The major presentation at the meeting will appear in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION and the committee has offered to present a similar program at other component medical societies when requested.

The committee has also studied a proposal to conduct a pilot blood information program in the Jackson area which would utilize the asso-

ciation's new 360/20 IBM computer. The program, when finally formalized, will be presented to the Board of Trustees and House of Delegates for approval.

Activities of the Council. In addition to the work of its several committees, the council has considered and acted upon other items of medical service interest. These will be the subject of a special supplementary report to be presented to the House of Delegates.

STATUS OF REPORT

The Speaker referred the Annual Report of the Council on Medical Service to the Reference Committee on Medical Practices. The reference committee made no comment or recommendation on the report which is, therefore, recorded for purposes of information.

SUPPLEMENTAL REPORT "A" OF THE COUNCIL ON MEDICAL SERVICE

Your Council on Medical Service has reported on the work of its several committees for the 1968-69 association year in the Handbook of the House of Delegates and respectfully commends this report to the attention of each member of this House of Delegates. Based upon its constitutionally assigned duries to ascertain and study all aspects of medical care in Mississippi and to report its findings in this connection to the profession your council has considered a wide range of subject areas and policy development during the 1968-69 association year which are presented for your action at this time.

Emergency Medical Care Services. Your council has continued its studies in this important public and professoinal area of interest. During the 1968 Regular Session of the Mississippi Legislature, legislation was proposed which would have required every public hospital in the state with 100 or more beds to have a physician on 24-hour emergency care duty. The association successfully opposed this legislation; however, it should be noted that 63 members of the 122 member House of Representatives saw fit to cosponsor the legislation. Additionally, in several hearings on the bill, there was much discontent expressed by legislators from all regions of the state with the way emergency medical care services were being handled in their communities.

Your council is cognizant of the fact that emergency care needs and services vary from community to community in our state. Also, oftentimes it appears that what the public views as an "emergency care problem" is really a problem of adequate communication between the public and the local medical community as to what emergency care services are available and why. Your council recommends the following policy statement on this subject for approval by the House of Delegates:

> "It is a direct responsibility of the medical profession in each community of the state to see that adequate emergency medical care services are provided in the community."

Physician Representation on Hospital Governing Boards. The council has surveyed each municipal and county hospital in the state as to the liaison maintained between its governing board and medical staff. The council received replies from 40 of 68 hospitals it surveyed. Twenty-three of the 40 hospitals which replied signified that they had a joint conference committee made up of members of the medical staff and hospital governing board and 3 of the 40 hospitals which replied have physicians serving as active members on their governing boards. The remaining 14 responding hospitals had no formal liaison mechanism between their medical staffs and governing boards.

Your council believes that it cannot too strongly recommend that the association continue to publicize and stress its policy recommendation on this subject adopted at the 99th Annual Session "that each hospital in the state have at least two voting doctors of medicine on its governing board who are either appointed or elected by the hospital medical staff from its membership." It should be noted in this regard that only 4 of the 14 hospitals replying that there was no formal liaison between their medical staffs and governing boards had formally requested such liaison.

Utilization Review Conferences. The council has considered a recommendation from its Health Insurance Benefits Advisory Committee that the association participate in a series of conferences over the state in the next few months dealing with the subject of utilization review in extended care facilities. The conferences are to be sponsored by the Mississippi State Board of Health's Medicare Certifying Unit. The House of Delegates will recall that with its approval in 1967 the council participated in a similar series of conferences dealing with utilization review in hospitals. The prior conferences were well received and the council recommends that the association endorse and participate in the proposed new conferences.

Accreditation of New Nursing Schools in Mississippi. The council's Committee on Nursing in its role to conduct a program of active liaison with the Mississippi Nurses Association and to consider subjects of mutual concern to the two professions has reviewed the present accreditation program for associate degree nursing schools in Mississippi conducted by the Board of Trustees of Institutions of Higher Learning. The committee has noted the present high failure rate among associate degree graduates taking the state nursing examination, the lack of national accreditation of any of the present associate degree programs except those at the University Medical Center and St. Dominics Hospital in Jackson and present plans to open at least three new associate degree programs.

The committee has also noted actions by the Mississippi Hospital Association and Mississippi Nursing Association calling upon the Board of Trustees of Institutions of Higher Learning to cease accrediting any new associate degree nursing programs until the present programs were strengthened and operating at full capacity and the committee recommends that the association join in this action. The committee also recommends that the House of Delegates join the hospital and nursing associations in urging the Board of Trustees of Institutions of Higher Learning to establish a master's program in nursing at the University Medical Center as one immediate and reasonable means of strengthening the supply of adequately trained faculty personnel for the several associate degree nursing programs presently accredited by the Board. Your Council on Medical Service approves the recommendations of the Committee on Nursing in urging adoption of these recommendations.

Officers of the Council. During the 1968-69 association year, the following served as officers of the council: Jack A. Atkinson, Brookhaven, chairman, and John G. Caden, Jackson, vice chairman. Other members of the council are: George F. Archer, Greenville; James O. Gilmore, Oxford; Jack M. Senter, Belmont; Paul B. Brumby, Lexington; William M. Gillespie, Jr., Meridian; Charles R. Jenkins, Laurel; and Bedford F. Floyd, Jr., Gulfport.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

The following majority report by three members of the reference committee, Drs. Scanlon, Egger, and Royals, was submitted and adopted. This portion omits comment and recommendations by the majority on the subject of mandatory licensure of nurses which is published separately with the minority report in this connection by Drs. Bolton and Shell. The minority did not dissent on the following portion of the majority report, but they were forbidden to sign the report under the Rules of Business.

Your Reference Committee on Medical Practice has carefully studied Supplemental Report A of the Council on Medical Services. For purposes of clarity the various portions of this report will be dealt with individually.

Emergency Medical Care Services. Your reference committee concurs with the policy recommendations of the Council on Medical Services and requests the adoption of the following as official policy of the Mississippi State Medical Association: "It is a direct responsibility of the medical profession in each community of the state to see that adequate emergency medical care services are provided in the community."

Physician Representation on Hospital Governing Boards. Your reference committee heard considerable testimony concerning the need for physician representation upon governing bodies of our county and city owned hospitals. Your reference committee heartily concurs with the policy decision stated at our 99th Annual Session in 1967. At that time the House of Delegates stated "that each hospital in our state have at least two voting doctors of medicine on its governing board who are either appointed or elected by the hospital medical staff from its membership." Despite a notable lack of progress in this area, your reference committee believes that this goal should be pursued vigorously. Your reference committee additionally recommends that a state law be sought which would require the presence of two licensed doctors of medicine, selected by the medical staff themselves, as full voting members on every county or county-city or city owned hospital.

Utilization Review Conferences. Your reference committee gave careful attention to the subject of Utilization Review Conferences for extended care facilities. Your reference committee agrees with the Council on Medical Service that it is desirable for the association to endorse and participate in the proposed new conferences.

Accreditation of New Nursing Schools in Mississippi. Your reference committee considered this subject at length and in depth. Your reference committee agrees that the level of instruction in our associate degree nursing programs needs to be increased in quality. Due to the present acute shortage of nurses, your reference committee feels that it would not be in the best interest of the people of Mississippi to arbitrarily

cease the creation or accreditation of new associate degree nursing programs. Your reference committee additionally recommends that the recruitment of young women into nursing programs, both baccalaureate and associate degree type, be intensively increased, and that a Masters Degree Program in Nursing Education be established at the University Medical Center or other Mississippi Institutions.

The foregoing majority report of the reference committee in which the minority did not dissent was adopted.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

The majority of the reference committee, Drs. Scanlon, Egger, and Royals, presented the following report:

Mandatory Licensure of Nurses. Your reference committee received extended debate and discussion concerning the pros and cons of mandatory licensure of nurses. The nurses licensing board of the state of Mississippi has for many years licensed those nurses capable of passing its tests and requirements. Hospitals and physicians in Mississippi are able to utilize graduate nurses in limited capacities until they become fully registered and licensed. If this mandatory licensing law were passed, such a practice would be impossible and the acute shortage of nurses would become even worse. Ideally all nurses should be highly educated, motivated and in plentiful supply, but such a pleasant situation regrettably does not exist. The majority of your Medical Practices Reference Committee believes that a bad situation would be made worse if mandatory restrictions were placed upon our hospitals and physicians in their utilization of graduate nurses. Another factor in our decision was that the reference committee did not have opportunity to examine the draft of the proposed mandatory licensure law; we are totally in the dark as to its provisions, scope and proposed application. Accordingly, a majority of your Reference Committee on Medical Practices rejects the mandatory licensure recommendation of our Committee on Nursing.

The chairman moved adoption of the majority report.

MINORITY REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Dr. Bolton presented the following minority report on behalf of Dr. Shell and himself:

Your minority membership of this reference committee dissents with the majority on the issue of mandatory licensure for nurses in Mississippi. We subscribe to the view that the quality of instruction should be substantially upgraded in all of our schools of nursing toward the end that we have competent bedside nursing for all of our patients. We believe that it avails us little to give quality instruction and then have weak licensure laws which in effect permit almost anyone to practice as a nurse. We feel that the licensure laws should be in the same context of quality as the instruction which we seek.

We therefore support the views of the Council on Medical Services's Committee on Nursing in supporting a mandatory licensure law for nurses in Mississippi. We also point out that of 51 United States jurisdictions including the 50 states and the District of Columbia, 42 states presently have mandatory nurse licensure laws while only 9 states including Mississippi have permissive licensure laws.

We believe as your minority membership that this is not a constructive and wholesome situation and we urge that the House of Delegates support a mandatory licensure law for nurses in Mississippi.

Dr. Bolton moved adoption of the minority report of the reference committee which became the pending business before the House of Delegates as a substitute motion. In discussion, Dr. Jack A. Atkinson of Brookhaven, chairman of the Council on Medical Service, explained that the recommendation of the Committee on Nursing, an *ad hoc* body of the council, had not been studied by the council because of insufficient opportunity to do so.

Dr. Atkinson moved that the entire matter, including the recommendations of the committee on mandatory licensure of nurses and the majority and minority reports be recommitted to the Council on Medical Service, second by Dr. Lamar Arrington of Meridian.

The motion to recommit was adopted.

SUPPLEMENTAL REPORT "B" OF THE COUNCIL ON MEDICAL SERVICE

Committee of the Council. Under the provisions of Section 2, Chapter IX, By-Laws of the association, the Council on Medical Service has three constitutional committees: Occupational Health, Maternal and Child Care, and Mental Health. These committees consist of not less than five nor more than seven members appointed for terms of three years each. The council also appoints *ad hoc* committees on a year-to-year basis.

Committee on Blood and Blood Banking. For

eight years, the council has maintained a five-member Committee on Blood and Blood Banking on an *ad hoc* basis. This has been one of the most able and productive committees of the association, having made studies of blood availability for transfusion services, presented testimony before the Legislature on crucial issues involving blood and blood banking, organized and presented two statewide seminars on blood banking, organized and established the plasmapheresis program at the Parchman State Penitentiary, and is now organizing an automated blood inventory program.

The Council on Medical Service believes that this committee should be accorded constitutional status and its members given tenure. This does not, however, affect the membership of the House of Delegates, since committee membership does not confer delegate and voting status.

Proposed Amendment. It is recommended that Section 2, Chapter IX of the By-Laws, be amended to add in the listing of constitutional committees the Committee on Blood and Blood Banking.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The Council on Medical Service has recommended that the Committee on Blood and Blood Banking be accorded constitutional status, thereby becoming the fourth constitutional committee of this council. The Committee on Blood and Blood Banking has served the association energetically and usefully and your council believes that this committee should be given continuity and tenure. We therefore approve this proposal and recommend that Section 2, Chapter IX of the By-Laws be amended to add this committee to the existing constitutional committees of the Council on Medical Service.

The report of the council, acting as a reference committee, was adopted.

AUXILIARY OFFICERS

The Speaker presented Mesdames Paul B. Brumby of Lexington, 1968-69 president of the Woman's Auxiliary to the Mississippi State Medical Assocation, and Louis C. Lehmann of Natchez, 1969-70 president, who addressed the House of Delegates.

ANNOUNCEMENTS BY THE BOARD OF TRUSTEES

Dr. C. D. Taylor, Jr., chairman of the Board of Trustees, announced that the Board had confirmed appointment of a new executive, Mr. H. C. Harrell of Jackson, on nomination by the Executive Secretary. Mr. Harrell will be Executive Assistant with additional duties as Office Manager effective May 19, 1969.

Dr. Taylor asked the House of Delegates to join the Board in commending Miss Cleta Brinson of Jackson who has served as recorder of the House of Delegates for 17 years. Miss Brinson is the incumbent president of the Mississippi Public Health Association. The House accorded Miss Brinson a standing ovation.

1969 MSMA-ROBINS AWARD

President Rogers presented the 1969 Mississippi State Medical Association-Robins Award to Dr. Omar Simmons of Newton for outstanding community service by a physician. Mr. Hiram Stewart of the A. H. Robins Co., co-sponsors of the award, a *bas* relief plaque, assisted Dr. Rogers in the presentation.

SPECIAL AMA AWARD

President Rogers presented a special plaque from the American Medical Association to Dr. Curtis W. Caine of Jackson for distinguished service in Viet Nam as a volunteer physician under the AMA-USAID program.

SCIENTIFIC EXHIBIT AWARDS

Dr. Walter H. Simmons, chairman of the Council on Scientific Assembly, presented the Aesculapius Award, an honorarium of $500, to Drs. Henry B. Tyler and Albert L. Meena of Jackson, for the best scientific exhibit by a member or members of the association. Dr. Tyler accepted for the exhibit authors.

Dr. Simmons announced that the Mississippi State Medical Association Scientific Achievement Award had been won by Dr. Charles W. Pearce of New Orleans. The award, a bronze medallion, is presented for the best scientific exhibit by a guest of the association.

RESOLUTION NO. 1, IN MEMORIAM

Dr. Walter H. Simmons: WHEREAS, There are absent from among our numbers 32 members who have been called by Divine Providence since the 100th Annual Session; and

WHEREAS, Although we are grieved upon the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

Irwin W. Barrett, Clarksdale, February 2, 1969
Bron-Dee Blackwelder, Quincy, Florida, January 2, 1969
William E. Box, Newton, February 21, 1969
Reuben B. Caldwell, Baldwyn, May 7, 1968
Homer F. Crumby, Woodland, May 1968
W. J. Daniel, Jr., Fulton, June 2, 1968
Carl A. Day, Yazoo City, February 14, 1968
George W. Eubanks, Greenville, April 20, 1968
Archie L. Gray, Jackson, March 4, 1968
Frank B. Hays, Columbus, January 1, 1968
Joseph C. Herrington, Rome, February 28, 1966
Homer L. Howard, Sr., Winona, May 1, 1969
Thack G. Hughes, Clarksdale, August 23, 1968
Nathan F. Kendall, Mendenhall, April 11, 1968
Charles H. Love, New Orleans, Louisiana, August 14, 1968
W. W. McBryde, Ethel, February 25, 1969
Amon K. McMillan, Lucedale, March 28, 1969
S. S. McNair, Jackson, June 5, 1968
Newton W. Mills, Richton, April 27, 1968
L. L. Minor, Memphis, Tennessee, March 2, 1968
Daniel H. Moore, Meridian, December 14, 1968
William H. Parsons, Vicksburg, March 9, 1969
Harry H. Puryear, Ethel, March 10, 1969
George F. Rembert, Jackson, January 2, 1969
J. S. Ruoff, Jr., Natchez, September 1, 1968
John C. Russell, Jr., Cleveland, January 10, 1969
Hunter L. Scales, Starkville, August 4, 1968
W. A. Stevens, Biloxi, March 14, 1968
P. R. Wasson, Lyon, February 27, 1968
W. H. Weeks, Yazoo City, March 20, 1968
B. Z. Welch, Biloxi, July 19, 1968
E. L. Wilkins, Clarksdale, December 12, 1968

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 2, PROFESSIONAL COMPENSATION FOR AUTOPSY, IN BEHALF OF THE PRAIRIE MEDICAL SOCIETY

WHEREAS, Existing state law limits payments to pathologists for autopsies ordered by a coroner or other proper authority, and

WHEREAS, The amount authorized by law is $75 or less, and

WHEREAS, It is believed that this is an inadequate compensation for the professional services involved, now, therefore, be it

Resolved, That the House of Delegates of the Mississippi State Medical Association seek amendment to existing law to provide for more proper and adequate professional compensation for this medical service.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

This resolution invites our attention to the present inadequate level of professional compensation for court-ordered medicolegal autopsies. The resolution requests that our association lend its efforts toward correction of the present inadequate statutory limitation of Section 7158 of the Mississippi Code of 1942, as amended. Your reference committee recommends that this resolution be adopted. We also recommend that the Board of Trustees of the association work out a suitable fee schedule with the executive committee of the Mississippi Association of Pathologists.

The report of the reference committee was adopted.

RESOLUTION NO. 3, JAMA LABORATORY ADVERTISING BY LEO J. SCANLON, JR., DELEGATE FROM ADAMS COUNTY

WHEREAS, The *Principles of Medical Ethics of the American Medical Association,* Section 8, requires physicians to obtain consultation in difficult cases or whenever it appears that the quality of medical service may be enhanced thereby, and

WHEREAS, Physicians consult with other physicians and not with industrial firms or laymen, and

WHEREAS, Many industrial firms and laymen are now attempting to practice medicine by way of displacing the physician who has specialized in pathology, and

WHEREAS, Both the American Medical Association and the Mississippi State Medical Association have repeatedly reaffirmed that the practice of pathology is the practice of medicine in an all relevant senses, and

WHEREAS, The *Journal of the American Medical Association* currently accepts advertisements of industrial concerns that solicit physicians to consult with them, and

WHEREAS, American physicians naturally trust the *Journal AMA* to provide the best in scientific and ethical standards, now, therefore, be it

Resolved, That the Mississippi State Medical Association express its belief that to replace physician-to-physician consultation with physician-to-industrial-firm consultation would be unwise and not in keeping with good medical practices, and be it further

Resolved, That this House of Delegates communicate its concern over such advertisements which appear in *Journal AMA* to the House of Delegates of the American Medical Association.

The resolution by the delegate from Adams County directs our attention to the advertising policy of the *Journal of the American Medical Association* with reference to laboratory services by industrial concerns which solicit physicians to consult with them. We approve the resolution which expresses the belief that physician-to-physician consultation should not be replaced with physician-to-industrial-concern consultation and that this is not in keeping with good medical practices. We further ask that our delegates to the American Medical Association introduce an appropriate resolution at the 1969 annual convention expressing this belief.

The report of the reference committee was adopted.

RESOLUTION NO. 4, IMPLEMENTATION OF PHYSICIAN-CORONER LAW, BY LEO J. SCANLON, DELEGATE FROM ADAMS COUNTY

WHEREAS, The Mississippi State Medical Association, at its 100th annual session, resolved that the county coroner should be a licensed doctor of medicine, and

WHEREAS, The Legislature and the Governor of the State of Mississippi have agreed with this principle and duly enacted House Bill No. 1110, The Physician-Coroner Act, into law July 18, 1968, and

WHEREAS, This law modernizes the office and increases its importance to the people of Mississippi, and

WHEREAS, Physicians are generally unfamiliar with the duties and privileges of this important county office, and

WHEREAS, Few physicians know how or have time to effectively organize and administer the necessary county level political campaign, now, therefore, be it

Resolved, That the Mississippi Medical Political Action Committee be requested to prepare educational material concerning the coronership and supply physician candidates with suitable material, coordination and expertise, and be it further

Resolved, That the Mississippi Medical Political Action Committee study the counties of Mississippi with the objectives of locating, encouraging and helping physician-coroner candidates, on a non-partisan basis, and be it further

Resolved, That the actions of the Mississippi Medical Political Action Committee first be approved and coordinated by the President and Board of Trustees of the Mississippi State Medical Association.

REPORT OF THE REFERENCE COMMITTEE
ON MISCELLANEOUS BUSINESS

This resolution asks that the Mississippi Medical Political Action Committee be requested to prepare educational material on the duties of the coroner and to furnish this to physician-candidates. MPAC is also asked to study the counties of the state, encouraging and assisting physician-candidates for the office of coroner. We approve the resolution and note that the approval of the Board of Trustees on the program outlined will be required. We recommend the adoption of Resolution No. 4.

The report of the reference committee was adopted.

RESOLUTION NO. 5, COMMITMENT OF MENTAL PATIENTS

Dr. Mal S. Riddell, Jr.: WHEREAS, Sections 6909-04, 6909-05, 6909-06, Mississippi Code of 1942, annotated, as amended by the laws of 1964, prescribe for the appointment and summons of two reputable, licensed physicians by the chancery clerk or chancellor for the purpose of conducting an examination of persons suffering from nervous or mental conditions as a precondition for commitment of such persons to a mental institution, and

WHEREAS, Section 6909-06 of the code provides in part that "the physicians making such examination and executing such certificate shall not be liable, civilly or criminally, in any case in which they exercise due diligence and reasonable care and act in good faith, without malice and upon reasonable cause," and

WHEREAS, Physicians fulfilling these duties prescribed by law and thereby acting for and in response to summons of a court have subsequently been sued by the person examined, and

WHEREAS, Such litigation, in the absence of exceptions provided by law as to malice, diligence, care, and reasonable cause, constitutes harassment and injury to those fulfilling lawful and court-prescribed duties as a uniquely qualified jury, now, therefore, be it

Resolved, That the Mississippi State Medical Association does call upon the Legislature for relief from such harassment and injury, does invite the attention of chancellors and chancery clerks to this practice, and does request that the Board of Trustees carefully consider remedies to correct this inequitable and injurious practice by assuring immunity from such allegation of liability.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

This resolution invites attention to harassing litigation arising out of physicians' fulfilling their duties in the examination of patients for commitment to mental institutions. The resolution asks that the association call upon the Legislature for relief from such harassment and injury, invites the attention of Chancellors and Chancery Clerks to this practice, and asks that the Board of Trustees carefully consider remedies to correct this inequitable practice by assuring immunity from such allegations of liability. We approve the resolution, recommend its adoption, and ask that it be referred to the Board of Trustees for implementation.

The report of the reference committee was adopted.

RESOLUTION NO. 6, PROFESSIONAL CORPORATIONS

Dr. J. A. K. Birchett: WHEREAS, For many years, general business organizations have been granted the privilege of incorporation to better manage their enterprises and to provide increasing benefits for their employees, this privilege having been denied professional groups, and

WHEREAS, There are many advantages to be gained through incorporation of professional groups, such as employee retirement programs, insurance programs, and business administration which will work to the benefit of both the corporation and the employee, and

WHEREAS, Recent actions of the courts of the United States support the validity of the incorporation of professional groups, now, therefore, be it

Resolved, That the Mississippi State Medical Association endorses the principle of the incorporation of professional groups, and be it further

Resolved, That the Mississippi State Medical Association support legislative action in the next session of the State Legislature to implement the incorporation of professional groups in the state of Mississippi.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

This resolution asks that the association support legislation to include physicians in state law permitting them to incorporate under Internal Revenue Service and Treasury Department regulations for the purpose of securing certain lawful tax benefits. We approve the resolution and recommend its adoption.

The chairman of the reference committee moved adoption of the report. In discussion, Dr. Dan Reikes of Hattiesburg suggested that the recommendation specifically apply to all physicains. Dr. S. S. Kety of Picayune moved that the first sentence of the reference committee report be amended to read "This resolution asks that the association support legislation to include all physicians, solo or group practice, in state law permitting them to incorporate. . . . " The motion to amend was seconded by Dr. Leo J. Scanlon, Jr., of Natchez.

The report of the reference committee was adopted as amended.

RESOLUTION NO. 7, CHARGES BY HOSPITALS FOR HOUSE STAFF SERVICES

Dr. Lawrence W. Long: WHEREAS, At least one hospital in Mississippi is making charges to patients for medical services rendered by interns and residents, and

WHEREAS, The purpose of internship and residency programs is the training of physicians and not the sale of medical services by a hospital, now, therefore, be it

Resolved, That no hospital may practice medicine by medical and/or surgical treatment of patients by interns, assistant residents, and residents in their training program and make such charges and collect such fees for their services as a third party, and be it further

Resolved, That only licensed physicians and surgeons in the state of Mississippi may practice on, make charges to, and collect fees from patients for services rendered, and be it further

Resolved, That any hospital found so doing shall have its medical staff charged by the censors committee of the component medical society as engaging in an unethical, unwholesome, and tax-dodging scheme, and if found guilty shall be removed from the rolls and membership of said society, the state medical association, and American Medical Association, and be it further

Resolved, That a report of such charges and actions shall be made to the Mississippi State Board of Health, the Mississippi State Tax Commission, and the U. S. Internal Revenue Service.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

The substance of this resolution centers about the practice of medicine by a hospital in the sale of medical services. We are agreed on this principle and your reference committee recommends

adoption of the following substitute resolution:

WHEREAS, At least one hospital in Mississippi appears to have made charges to patients for services rendered by house officers, and

WHEREAS, The primary purpose of internship and residency programs is the training of physicians, now, therefore, be it

Resolved, That the Mississippi State Medical Association reaffirms its belief that no hospital should sell the services of a physician, and be it further

Resolved, That reaffirmation of this principle in no way affects ethical and proper arrangements between hospitals and pathologists and hospitals and radiologists or ethical and proper arrangements made for emergency medical services in hospitals.

Your reference committee believes that reaffirmation of this principle is sufficient and we recommend adoption of the substitute resolution.

The report of the reference committee was adopted.

RESOLUTION NO. 8, REDUCTION OF CERVICAL CANCER

Dr. O. B. Wolley: WHEREAS, Cancer of the uterine cervix is a leading cause of death among Mississippi women, despite the established fact that pre-invasive cancer of the cervix is virtually 100 per cent curable, and

WHEREAS, The merits of the Papanicolaou cervical cytology smear are firmly and clearly established, in the last published survey of the American Cancer Society, despite encouraging and significant progress recently, Mississippi ranked in the lowest national percentile with only 14 per cent of women studied, and

WHEREAS, There is a notably high correlation between early diagnosis and successful salvage rate with this type of cancer, now, therefore, be it

Resolved, That the Mississippi State Medical Association does endorse and encourage annual cervical cytology in adult Mississippi women and does call upon every Mississippi physician and all concerned professional and allied professional organizations to participate actively in this effort with the goal of reduction, even irradication of cervical cancer, a potentially preventable disease.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

This resolution was introduced by the Chairman of our Section on Obstetrics and Gynecology. It calls upon the Mississippi State Medical Association to support the establishment of an *ad hoc* committee for the specific purpose of coordinating an educational program among physicians and laymen in the proper use of the vaginal Pap Smear. Your reference committee agrees with this resolution. We additionally state that our association is the logical one to coordinate the efforts of the many lay groups presently engaged in public education concerning the vaginal Pap Smear. Every Mississippi woman should have a yearly Pap Smear. The creation of this *ad hoc* committee for coordinating the education program in our state would be a good example of leadership by the medical profession.

The chairman moved adoption of the report of the reference committee. In discussion, Dr. Jack A. Atkinson suggested that the implementation of the resolution be referred to the Council on Medical Service. The report of the reference committee was adopted.

RESOLUTION NO. 9, SCHEDULING OF ANNUAL SESSION

Dr. C. D. Taylor, Jr.: WHEREAS, The Mississippi State Medical Association traditionally convenes in annual session during the second week in May, and

WHEREAS, This date almost invariably conflicts with Mother's Day, and

WHEREAS, Municipal elections in Mississippi are conducted on the second Tuesday in May, and many physicians in attendance upon the annual session are therefore unable to discharge their responsibilities as electors, and

WHEREAS, It is desirable to avoid these conflicts and to schedule the annual session at a time of optimum convenience to physicians and their families, now, therefore, be it

Resolved, That the Board of Trustees is empowered to alter the date of the annual session so as to avoid these conflicts and to make such changes as are necessary and possible in contracts with the headquarters hotel to accomplish this purpose.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

The resolution points out that the present scheduling of the annual session is such that we usually have a conflict with Mother's Day and with municipal elections in the years which they are held in Mississippi. The resolution seeks to resolve these conflicts by authorizing and empowering the Board to make such rearrangements as are possible with the headquarters hotel at which we meet.

We approve the resolution and in recommend-

ing its adoption ask that the Board make only such changes in scheduling as are necessary to avoid the conflicts stated.

The report of the reference committee was adopted.

OFFICIAL ATTENDANCE

The official attendance was announced as being 924 to include 503 physicians, both members and guests, 242 members of the Woman's Auxiliary, 165 exhibitors and other guests, and 14 staff.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Conduct of Business. Your reference committee commends the Speaker and Vice Speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this connection and an expression of appreciation to these officers.

Resolution. Your reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 101st Annual Session of the Mississippi State Medical Association has been conducted in Biloxi, Mississippi, during the period May 12-15, 1969, and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance, now, therefore be it

Resolved, That expressions of deep appreciation are made to the officers, Trustees, and Council on Scientific Assembly for the stimulating and worthwhile scientific program; to the management of the Buena Vista and other participating hotels; to the press, radio, and television for coverage of our activities; to the gracious ladies of the Auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional service representatives; to our scientific exhibitors; to our distinguished guests; and to all who shared in the responsibilities of planning, organizing, and conducting this great annual session.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

REPORT OF THE ELECTION OF OFFICERS

President-elect: Paul B. Brumby, Lexington.

Vice Presidents: G. Leroy Howell, Starkville; J. Dan Mitchell, Jackson; Jack A. Atkinson, Brookhaven.

Editor: W. Moncure Dabney, Crystal Springs.

Associate Editor: Thomas W. Wesson, Tupelo.

Delegate to AMA: G. Swink Hicks, Natchez.

Alternate Delegate to AMA: Joseph B. Rogers, Oxford.

Board of Trustees: W. E. Moak, Richton, District 7; Everett Crawford, Tylertown, District 8; James T. Thompson, Moss Point, District 9.

Council on Budget and Finance: George D. Purvis, Jackson.

Council on Constitution and By-Laws: Tom H. Mitchell, Vicksburg.

Council on Medical Education: Dennis E. Ward, Corinth.

Council on Legislation: A. T. Tatum, Petal, District 7; David L. Clippinger, Hazlehurst, District 8; C. D. Taylor, Jr., Pass Christian, District 9.

Judicial Council: Arthur A. Derrick, Jr., Durant, District 4; William B. Wiener, Jackson, District 5; Charles M. Moore, Philadelphia, District 6.

Council on Medical Service: John F. Lucas, Jr., Greenwood, District 1; James O. Gilmore, Oxford, District 2; Jack A. Stokes, Pontotoc, District 3.

State Board of Health (nominations to the Governor): *Public Health District 2:* G. Lacey Biles, Sumner; Julian C. Bramlett, Oxford; John R. Lovelace, Batesville.

Public Health District 4: S. Lamar Bailey, Kosciusko; Thomas N. Braddock, Jr., West Point; Lester D. Webb, Calhoun City.

Public Health District 5: Lamar Arrington, Meridian; John R. Laird, Union; Omar Simmons, Newton.

CONSTITUTION AND BY-LAWS

At the close of business, there were no pending amendments to the Constitution or By-Laws.

CLOSING CEREMONIES

There being no further business, the Speaker returned the gavel to the President, Dr. Rogers. The Oath of Office was administered to Dr. James L. Royals, the President-elect, by Dr. C. D. Taylor, Jr., Chairman of the Board of Trustees after which Dr. Royals addressed the House of Delegates.

Dr. James Grant Thompson of Jackson presented the Thompson Memorial Past President's Pin to Dr. Rogers.

The House of Delegates was adjourned *sine die* at 4:59 o'clock in the afternoon, May 15, 1969.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo.; Annual Convention, June 21-25, 1970, Chicago. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 102nd Annual Session, May 11-14, 1970, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joseph B. Miller, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 1237, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Mary's Restaurant, Hernando, Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. Edward Pennington, Ackerman, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

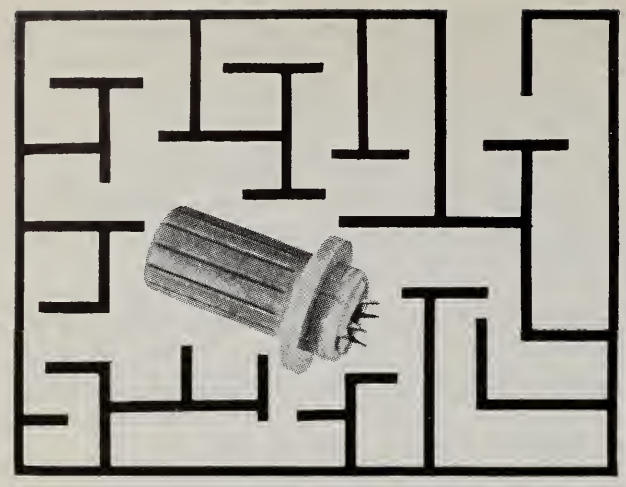
Prairie Medical Society, Second Tuesday, March, June, September, and December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

Singing River Medical Society, Third Monday January, March, June, September, and December. Donald E. Dore, Singing River Hospital, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. W. B. White, 1007 Jefferson Street, Laurel, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.



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Articles for Publication

Manuscripts should be typewritten, double spaced on one side of the paper. Tables, charts, and tabulations should be submitted on separate sheets but their position in the text should be indicated. Authors are encouraged to limit bibliographies to 10 references, written in conformation to style utilized in scientific publications of the American Medical Association. Articles are accepted for publication on the condition that they have not been previously published and are contributed solely to this JOURNAL.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text. Figures and drawings are acceptable when prepared with black ink on white paper. Photographs for illustrations should be unmounted, untrimmed, glossy prints and all such material must be identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Reprints may be obtained at cost from the association. The right is reserved to decline any manuscript for publication. Ordinarily, manuscripts submitted will be acknowledged whether published or not.

Index to Advertisers

Breon Laboratories 384A, 384B, 384C, 384D
Bristol Laboratories 356A
Burroughs-Wellcome **14D**

Geigy Pharmaceuticals **8, 9, 10**

Highland Hospital **15**
Hillcrest Hospital 373
Hynson, Westcott and Dunning, Inc. **3**

Kay Surgical **6**

Lakeland Nursing Center **17**
Lederle Laboratories **4, 6, 18,** 366, 368A, 373, 400
Eli Lilly **front cover, 20**

William S. Merrell Company **16**

National Drug Company **second cover, 18A, 18B**

Parke, Davis and Co. 356D
Pitman-Moore Company 368B, 369

Riker Laboratories **12, 13, 19,** 359, 360
Roche Laboratories **14, 14A, 14B, 14C, back cover**
William H. Rorer **11**

Searle 356B, 356C
Smith, Kline & French **7,** 379
Stuart Company 371

Warner Chilcott Laboratories 360A, 360B
Wyeth Laboratories 376, 377

Thomas Yates and Company **third cover**

Volume X
Number 9
September 1969



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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CONTENTS

ORIGINAL PAPERS

Liver Scanning **401** W. M. FLOWERS, JR., M.D.

The Delta Pilot Project A Transport System for Newborns With Respiratory Distress Syndrome **406** ALFIO RAUSA, M.D.

412 L. J. ARP, Ph.D.; R. E. DILLON; MARY TOM LONG, M.D.; and C. L. BOATWRIGHT, M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXVII: Gas in the Biliary System **410** KENNETH O. WILLIAMS, M.D.

Dr. James Marcus Taylor: Member First Mississippi State Board of Health **417** BEULAH M. PRICE

EDITORIALS

The Delivery of Health Care: A System on Trial **421** Society—Not the System

Moon Bugs Are No Laughing Matter **425** Exobiology

Changing Views on Therapeutic Abortions **425** New State Laws

Robins and Richmond: Education Hallmark **426** Record Endowment

A Choice for the Physician **426** Separate Billing

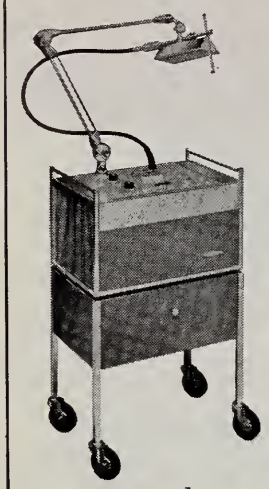
THIS MONTH

The President Speaking **420** A Matter of Equity

Medical Organization **441** Emergency Care Unit Opens to Serve Legislature

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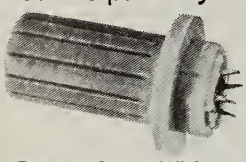
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Baptist Hospital Opens Coronary Care Unit

Mississippi Baptist Hospital in Jackson has opened its new six-bed coronary-care unit for patients. "This unit," said hospital administrator Paul J. Pryor, "is the culmination of long and careful planning. It is a self-contained unit, designed for maximum surveillance of the patients."

Sliding glass doors for each patient area will enable nurses to keep constant watch from their station and permit patients to see the nurse.

Nurses at the hospital have concluded weeks of special training to prepare themselves for duty in the new unit, located on the second floor. Two registered nurses and a licensed practical nurse will be on duty in the unit during the two day shifts, and one registered nurse and a licensed practical nurse will be on night duty.

"Every piece of monitoring and life-saving equipment is immediately available, so that nurses will not have to leave the area," said Mrs. Shirley Clemons, assistant director of nursing service.

Pryor also pointed out that the hospital's staff of six interns will be getting some of their training in the unit.

"The unit," said the administrator, "will provide quiet and pleasant surroundings for the patients. A cheerful and relaxed atmosphere is of special importance to this type of patient."

The unit includes individual monitors for each patient, thus assuring continuous observation from the central nursing station just a few feet away.

Each of the six rooms includes an all-electric bed, thermostat controls, oxygen supply, electric outlets for emergency use, and piped in music with volume control.

Family Practice Offers Challenge

Medical students and young physicians will be interested in the report of the ad hoc committee on education for family practice prepared by the Council on Medical Education of the American Medical Association.

Published originally in 1966, the report, "Meeting the Challenge of Family Practice," defines the functions, training, requirements, and postgraduate opportunities for the physician in family health care. Copies are available from the Department of Undergraduate Medical Education of the AMA.

Tax Surcharge Extension Ups Estimated Payments

Mississippi taxpayers may have to increase estimated income tax payments if the 10 per cent tax surcharge is extended beyond June 30, J. G. Martin, Jr., district director of Internal Revenue, said today.

A reminder notice mailed to taxpayers making 1969 estimated tax installment payments, points out that the worksheets taxpayers used to make their declarations show the surcharge rate as 5 per cent (one-half year at 10 per cent). If the surcharge is extended by Congress, the estimated tax due for 1969 will have to be recomputed using the new rate.

If the extension comes before the June 16 installment due date, taxpayers should make the necessary changes in that payment. Mr. Martin suggested that taxpayers watch the newspapers, radio and television for information on changes in the surcharge rate.

Reminder notices for the June estimated tax installment were sent to every taxpayer who received estimated tax forms last February based on possible liability for payment. Taxpayers who are not liable for estimated tax payments should disregard the notice.

If a taxpayer is required to make estimated tax payments, but does not have the new voucher forms, he may obtain them by dropping a post card to the district director's office.

AMA Speakers Program Cited

The American Medical Association's Speakers Program was recently honored by the Publicity Club of Chicago and received its Golden Trumpet Award for the best public relations special program during the year.

Since the Speakers Program was launched in early 1967, over 1,500 physicians have been briefed on effective delivery in 38 seminars conducted by the AMA staff throughout the U. S. These speakers are now addressing community audiences, and many are experts in specific fields of medicine and health.

The Office of the Executive Vice President of the AMA is offering kits of aids to medical societies to help advance the effectiveness of their speakers bureaus.



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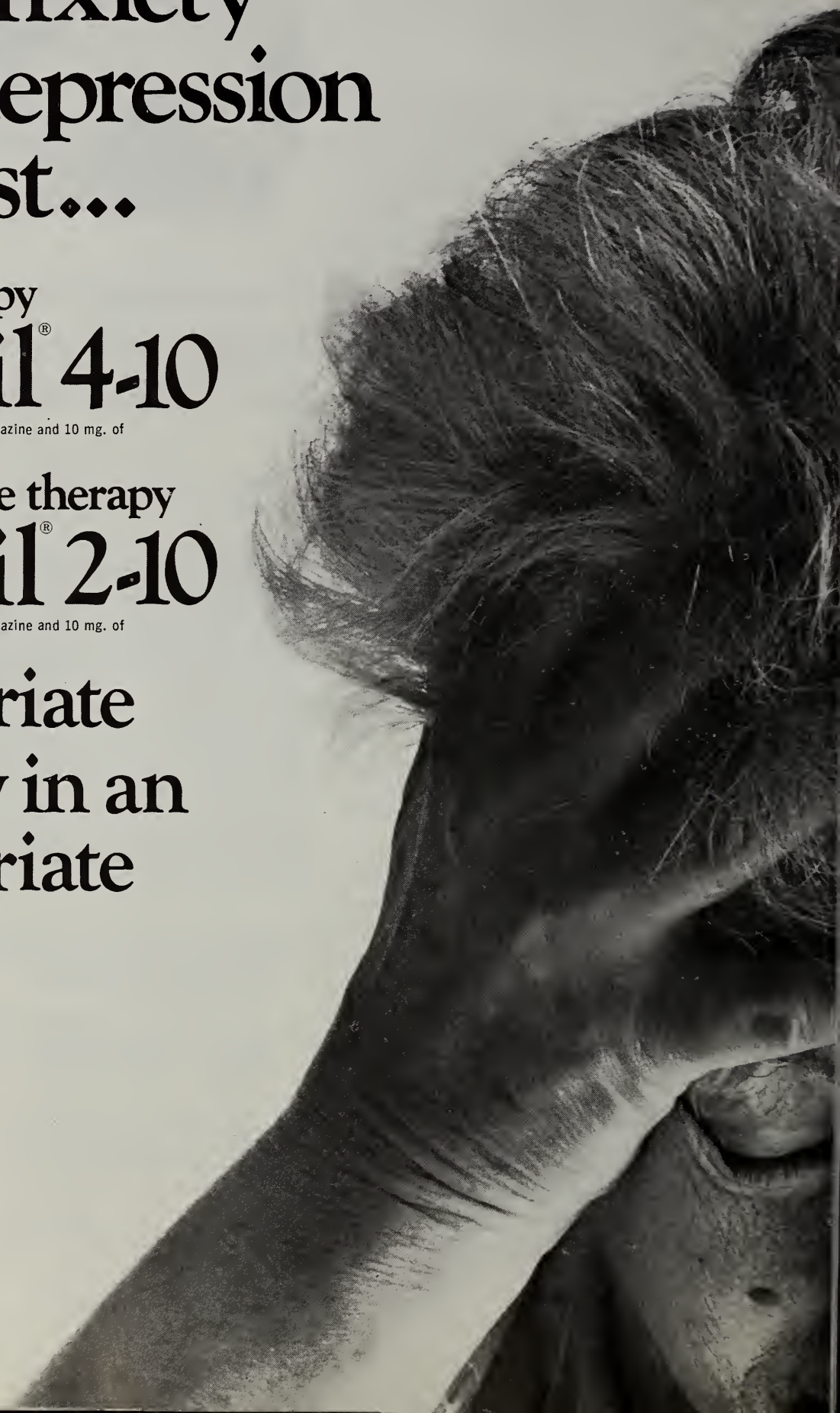
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

September 1969

Dear Doctor:

Amid death, devastation, and suffering wrought by killer Camille, the Mississippi health care team wrote another chapter of service. First and most effective line of defense was by Coast physicians who worked heroically under hardship and disadvantage, serving all in need of care. But Mississippi colleagues outside Coast area were generous in volunteering and responding to calls for help.

> Dr. James L. Royals, association president, was one of first upstate physicians on the disaster scene. Throughout critical week following hurricane, he returned to area, making assessments and furnishing leadership.

Even before storm hit, Dr. Kenneth M. Heard of Jackson took 90 units of blood to Coast, prepositioning it at Gulfport. Jackson and Hattiesburg surgeons responded to calls in early post-storm hours. University Medical Center organized and dispatched first team of physicians and nurses to Coast as organized efforts jelled. A second team of physicians and nurses was organized from Starkville-Columbus and Jackson areas, but improved Coast manpower situation permitted withdrawal. Literally hundreds of Mississippi physicians and nurses volunteered services to association, and physicians volunteered from as far as Illinois, Ohio, Indiana, and Texas.

On third post-storm day, association was asked to coordinate medical support requested from entire Coast area. Communications were difficult to impossible, and President Royals handled on-site requests and outlined projects. Biggest operation was airlift of 118 nursing home patients from Pass Christian to Meridian and was coordinated by MSMA.

Meridian physicians and hospitals responded superbly, and citizens furnished patient transportation in station wagons. Patients were lifted by helicopters from Pass Christian to Gulfport and thence by Air National Guard to Meridian. Key figures were Charles Flynn of hospital association who secured beds, Brig. Gen. G. M. McWilliams who commanded airlift, M.D.'s of East Mississippi Medical Society, and hospital leaders.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

IRS Corporation Reversal May Be Empty Gesture

Washington - The big print gives it to you, and the fine print may take it away. The Internal Revenue Service's announcement that it will not appeal pending cases against professional corporations and physicians, attorneys, and others who are incorporated may be offset by tax reform now before Congress. Bill states that professional corporations taxed under Subchapter S are limited to benefits not exceeding those of Keogh. Subchapter S taxes income to shareholders as if they were partners.

Reuther Presses For National Health Plan

Detroit - The Committee of 100, headed by UAW President Walter Reuther, is renewing efforts for national compulsory health insurance. AFL-CIO supports program, arguing that it should be an extension of Medicare with same administrative mechanism. Financing, however, would be equally shared by employers, employees, and federal government. Organized labor says system would not be like British socialized medicine but merely a financing mechanism, but proponents would drastically change the delivery system of private practice.

Hill-Burton Emphasis Shifts

Washington - The U. S. Public Health Service says that local use of Hill-Burton funds has shifted from construction to modernization. In 1948, first full year of program, 80 per cent of money went to construction. In 1968, modernization expenditures accounted for 96 per cent of funds. Need for new and additional hospital beds is mainly in cities where Hill-Burton priorities have been low.

New California RVS Will Be Released

San Francisco - The 1969 California Relative Value Studies will be available Oct. 1, according to state medical association sources. New edition will have half again as many procedure listings as 1964 edition which it supersedes. Value ranges will be substantially changed with principle of "modifiers" to indicate increased or lowered fee for a procedure. Codes will be changed to five digits from present four. New RVS becomes effective in California April 1, 1970.

AMA Hits HEW On Unfairness Of Earnings Disclosure

Chicago - AMA has strongly protested practice by HEW and Social Security Administration of releasing names of physicians who earned $25,000 or more a year under Medicare or Medicaid. Payments of $193,000 to Dr. Denton Cooley and $202,000 to Dr. Michael DeBakey made national news. Most of it went to special medical school funds, however. Part 1-B carriers are now under instructions to make monthly reports on physicians earning $25,000 or more in 1968 on "unusual practices."

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Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering NORGESIC to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

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Agency Launches Anti-Drug Program

The National Institute of Mental Health joined a number of other organizations this spring to accelerate the dissemination of education on the dangers of drug abuse. Washington, D. C., media was the pilot community, with emphasis on radio and television, prior to an all-media national effort.

Commercials stress the legal penalties for possession of marijuana and stress the indiscriminate use of unprescribed amphetamines, barbiturates, narcotics, and LSD. The Institute is also utilizing public service messages in newspapers, magazines and on billboards, posters and bus and subway cards. The campaign is aimed at youths, parents, the addicted, and ghetto dwellers who are often the prey of heroin peddlers.

These materials may be requested from Ronald McMillen, Office of Communications, NIMH, 5454 Wisconsin Avenue, Chevy Chase, Maryland 20015.

PPF and Wyeth Make New Film

Contraceptive methods are reviewed for hospitalized postpartum women in a film now available through the Planned Parenthood Federation, Inc. The film, titled "Happy Family Planning," was produced under a financial grant from Wyeth Laboratories.

"Happy Family Planning" is an entertaining 8-minute animated color film with music, available in either 16-mm. or 8-mm. The film, which presents its story in graphic devices and requires no dialogue, features various contraceptive devices which are identified in five languages: English, French, Spanish, Arabic and Chinese.

The film is designed for showing to lay groups, especially hospitalized women in the immediate postpartum period. It also can serve as a valuable educational aid in clinics, physicians' offices and at health meetings. The film is very useful where there is a language barrier, at all educational levels.

Prints of "Happy Family Planning" can be purchased at cost through Planned Parenthood Federation, 515 Madison Avenue, New York, New York 10022.

Physicians Sought for Pesticide Study

The Bureau of Medicine's Pesticides Program is currently seeking several physicians to serve as Medical Epidemiologists studying the effects of pesticides upon the local populace, reports J. J. Jennings, M.D., acting director of HEW's Bureau of Medicine.

These physicians will participate in intensive, long-term studies on approximately 150 occupationally exposed individuals, acute poisoning cases as they occur, and lesser studies on samples of the general population. Another duty is to provide professional liaison with the local practitioners, pathologists, and hospitals to stimulate awareness of the dangers of pesticides.

"We are presently recruiting for a position located at Mississippi State University at Starkville," said Dr. Jennings. Those interested should forward a current curriculum vitae to him at the following address: P.O. Box 2000, Eads Station, Arlington, Virginia 22202.

Starting salaries range from $18,249 to $19,771 depending on qualifications.

AMA Offers Savings on Smoking Posters

Even the most determined "reformed" smokers slip back to the weed, and even the most aggressive non-smoking campaigns can become equally lax without the infusion of new educational materials. To keep the reformed reformed and the abstainers abstained, the AMA now offers two new anti-smoking posters—"Best Time to Stop Smoking" and "Break the Habit"—in colorful artwork, 18×23″, at below-cost prices.

Orders should be sent to the AMA Order Department; singles at 20¢, 50-99 at 18¢, 100-499 at 16¢, 500 to 999 at 14¢, and 1,000-up at 12¢. These remarkably low prices are established because the AMA is absorbing distribution and promotion costs to encourage maximum exposure of this important campaign.

These posters are effective in all well-trafficked areas, and with the resumption of the autumn school term, they are recommended for bulletin boards in all schools and colleges.

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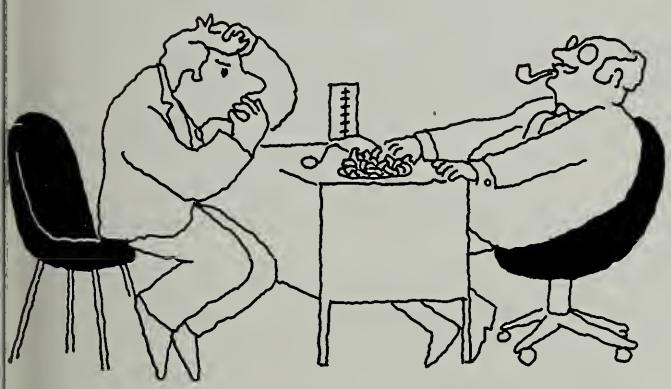
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AMA Auxiliary Schedules Meetings

The Woman's Auxiliary to the American Medical Association has issued invitations to its officers, committee chairmen, presidents and presidents-elect at the national and state level to attend the Auxiliary's Annual Fall Conference October 5-8 at the Drake Hotel, Chicago.

The keynote speaker at the conference will be Gerald D. Dorman, M.D., New York, AMA president.

Four additional regional meetings have been scheduled by the Auxiliary this autumn to strengthen and further state participation in its nationwide projects. Representatives invited to attend these workshops in the geographic sections concerned are the state president, president-elect, and the chairmen of the Committees on the AMA Education and Research Foundation, Children and Youth, Health Careers, Legislation and Membership.

The four regional workshops as scheduled are:

Western: Scottsdale-Phoenix, Arizona, Hotel Safari, October 13-14;

Southern: Dallas, Texas, Statler Hilton Hotel, October 16-17;

North Central: Kansas City, Mo., Hilton Inn, October 20-21, and

Eastern: Washington, D. C., Sheraton Park Hotel and Motor Inn, October 23-24.

Foreign Grads Up U.S. M.D. Pool

With the health manpower shortage, the U. S. benefits from the influx of foreign medical school graduates. In 1968, approximately 2,375 physicians from foreign schools entered the country to practice. This figure includes 173 graduates, both American and foreign, from Canadian medical schools.

In addition, the July issue of the *Journal of Medical Education* reports on the number of American graduates of foreign medical schools (in addition to Canadian) who were "students who transferred from foreign to U. S. medical schools in advanced standing in the years 1959 through 1966."

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AMA Announces Film "The Team Physician"

How to minimize athletic injuries is the subject of the AMA's newly produced motion picture, "The Team Physician." It is recommended for coaches, school administrators, parents and athletes, as well as physicians and outlines the role of the attending physician in preventing injuries. The narrator, Bud Wilkinson, stresses the five basic regulations of a safe school sports program: training and conditioning, good equipment, good coaching, good officiating, and proper health supervision.

The film is 16mm, color-sound, and 28 minutes, now available to the profession from the AMA Film Library. Lay requests should be directed to Modern Talking Picture Service, Prudential Plaza, Chicago, Ill. 60601, with a 30-day advance order.

This free film (return shipping cost only) has universal appeal: for medical societies, schools, colleges, hospitals, TV, Woman's Auxiliaries, health councils, and all youth organizations.

Reflectorized Clothes Urged for Children

The American Academy of Pediatrics has strongly recommended that retro-reflective materials such as reflectorized tags attached to a child's coat zipper be worn by children at night. This, the Academy emphasizes, will help to significantly reduce the more than 1,000 childhood deaths attributed each year to poor visibility during evening hours.

In a statement appearing in a recent *Newsletter,* the Academy Committee on Accident Prevention encourages the development of various commercial reflectorized material to make pedestrians readily visible to drivers at night.

Retro-reflectorized materials, the Academy statement emphasizes, can either be affixed to clothing, or incorporated in the design of a garment.

The Academy further recommends that more information concerning traffic safety be given to pediatric patients.

The American Academy of Pediatrics has more than 10,800 members in the United States, Canada, and Latin America.

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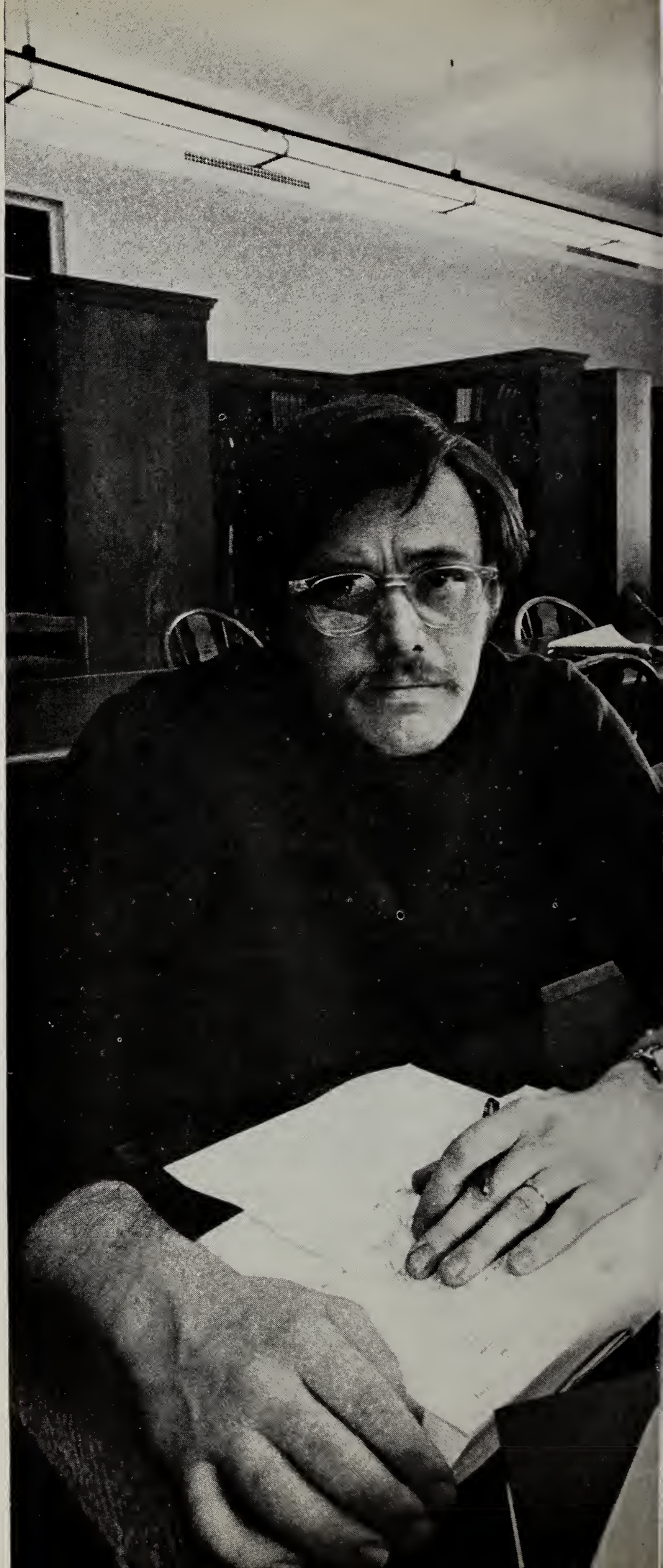
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1969, Vol. X, No. 9

ORIGINAL PAPERS

Liver Scanning

W. M. FLOWERS, JR., M.D.
Jackson, Mississippi

LIVER SCANNING is a safe, simple and atraumatic method of producing an image of functioning hepatic parenchyma and results in unique diagnostic information. It is possible to visualize organ size, shape and intra-abdominal location. The study is most commonly used to demonstrate focal lesions such as tumors or abscesses, but there are other important indications.

The demand for this procedure continues to increase, and scanning equipment is becoming widely available. It seems appropriate, therefore, to discuss the indications, interpretation, and limitations of liver scanning.

The liver scan frequently provides important diagnostic information in the following situations:

1. evaluation of the liver for metastatic disease in patients with known or suspected malignancies,
2. differential diagnosis of upper abdominal masses,
3. evaluation of suspected right upper quadrant inflammatory disease or abscess,
4. assessment of hepatic size, configuration and position,
5. differentiation of focal lesions from diffuse parenchymal disease,
6. localization of focal lesions prior to needle biopsy or surgical exploration,
7. localization of abscesses prior to aspiration or drainage,
8. serial scans to evaluate the effectiveness of chemotherapy in patients with hepatic malignancies,

Hepatic photoscanning is a more accurate method of diagnosing space occupying hepatic lesions than any other single clinical test. The study is most commonly used to demonstrate focal lesions such as tumors or abscesses, but there are other important indications. The author discusses the indications, interpretation, and limitations of liver scanning.

9. evaluation of liver involvement after abdominal trauma,
10. differential diagnosis of jaundice.

Hepatic cells and reticulo-endothelial cells are evenly distributed throughout the liver. Physiological mechanisms of either cell type can be exploited to selectively accumulate tracer materials, and several scanning agents are available.

Rose bengal tagged with radioactive iodine was the first agent used for liver scanning. The hepatic cells, also called polygonal cells because of their polyhedral shape, will remove this material from

From the Department of Radiology, University of Mississippi School of Medicine.

the blood stream and excrete it through the biliary system. Maximum accumulation in the liver occurs in 30 to 60 minutes, but by this time biliary excretion into the gall bladder and bowel can cause overlapping radioactivity distributions that interfere with interpretation of the liver image. However, this characteristic has been used to advantage in the evaluation of jaundiced patients, since excretion of the isotope into the bowel rules out extrahepatic obstruction. Iodipamide I-131 (Cholografin) is also concentrated by the polygonal cells and excreted through the biliary system. Its behavior is similar to rose bengal I-131, but it is not widely used.

Colloidal gold-198 is presently the most popular liver scanning agent in routine use. Particles from 0.1 to 1 micron in size are phagocytized by the reticulo-endothelial system, and about 80 to 90 per cent are trapped by the Kupffer cells of the liver. Normally, 5 to 10 per cent go to the spleen, and the rest to the bone marrow. It is generally agreed that colloidal gold-198 produces better images of the liver than rose bengal I-131. The problem of biliary and intestinal excretion does not occur, but the irradiation dose to the liver is higher. Once trapped, the colloidal particles remain indefinitely in the Kupffer cells.

INJECTION MATERIALS

Iodine-131, labeled human serum albumin, will form aggregates when prepared by controlled heat destruction, and particles of the proper size can be obtained for liver scanning. Following injection there is rapid phagocytosis by the reticulo-endothelial cells. The tracer distribution and scan appearance are similar to that of colloidal gold I-131, but there is more radioactivity in the spleen. The peak hepatic activity occurs within 10 to 15 minutes, but falls to about 50 per cent in 40 to 60 minutes. The colloidal particles undergo proteolysis and escape from the liver, so scanning must be done rapidly. If the thyroid gland is blocked with Lugol's solution, the free radioactive iodide is excreted in the urine.

Technetium 99m sulfur colloid is an excellent liver scanning agent, providing very high count rates, an ideal gamma ray energy, and a minimum of patient irradiation. Its distribution in the liver is similar to colloidal gold. It must be prepared locally by the user prior to each study and for that reason is not as widely used as the other tracers.

IMAGING DEVICES

There are two basic types of devices that are used to produce images of radioisotope distributions in human organs and tissues.

The rectilinear scanner has a moving detector that travels back and forth across the area of interest. Gamma rays, emitted from the radioactive isotope within the body and penetrating through to the scanner head, are converted to flashes of light by a thallium activated sodium iodide crystal, then to electronic pulses by a photomultiplier tube. These pulses are processed by digital and analog electronic circuits, and finally an optical or mechanical system builds up the image line by line.

Radioisotope cameras are relatively new instruments for imaging gamma ray emitting isotopes. They produce pictures similar to those made by rectilinear scanners but in much less time. A large, thin sodium iodide crystal, optically coupled to an array of 19 photomultiplier tubes, views the area of interest and produces a flash of light, or scintillation, at the site of interaction of



Figure 1. Normal liver scan, anterior view.

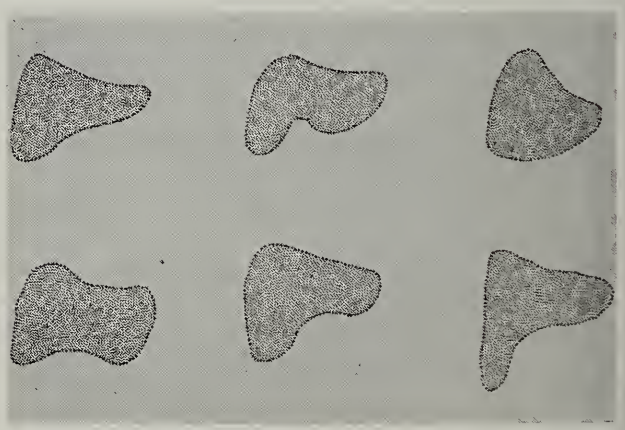


Figure 2. Normal variations in liver contour.

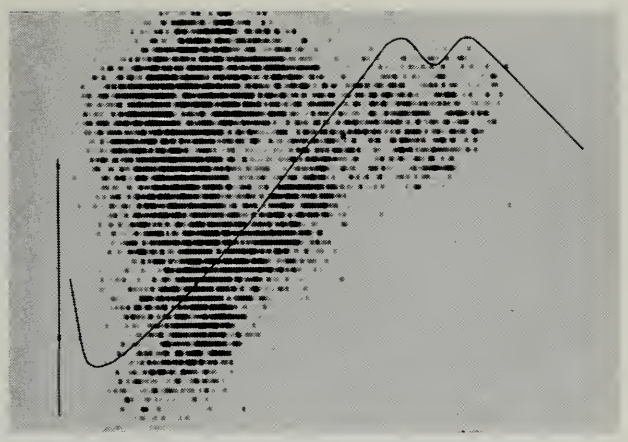


Figure 3. Focal filling defect due to metastatic carcinoma.

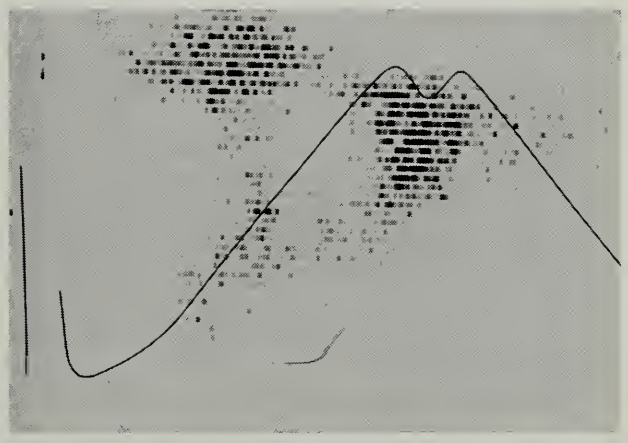


Figure 4. Multiple focal filling defects due to metastatic carcinoma.

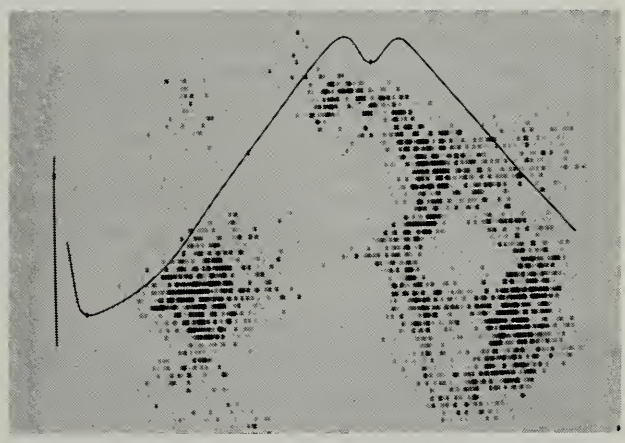


Figure 5. Hepatomegaly with massive replacement of liver parenchyma by metastatic disease.

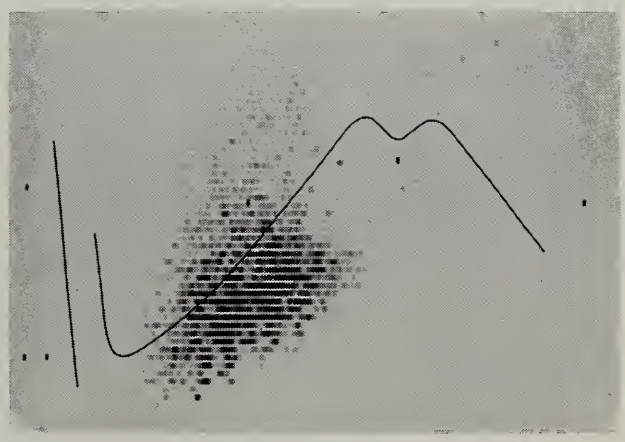


Figure 6. Hepatoma. A large, poorly defined filling defect replaces a considerable portion of the liver. The right hepatic border is displaced from the abdominal wall by ascites.

each gamma ray. The position of each scintillation is determined by a computer network that electronically measures the relative amount of light seen by each photomultiplier tube. Each event is recorded as a point flash of light in proper position on an oscilloscope screen with a Polaroid camera, or other suitable optical device.

Accurate evaluation and interpretation of liver scans require correlation of the scan with clinical history, physical findings, radiographic and laboratory data in any given case.

Liver enlargement is the most common abnormality demonstrated by hepatic scanning. The most frequent causes are malignancy, cirrhosis, fatty infiltration, chronic passive congestion and hepatitis. In general, any process that can cause the liver to enlarge will be reflected by an enlarged liver image. It is unusual to encounter an abnormally small liver on a scan. Occasionally the finding is an artifact due to improper technical setting. The most common etiologies are cirrhosis and diffuse metastatic disease. However, enlargement of the liver is much more common in both these processes.

LIVER DISPLACEMENT

Displacement of the right border of the liver from the abdominal wall occurs most commonly with ascites but has been seen with interposition of the colon. Downward and medial displacement is most commonly due to subphrenic abscess. It is possible for the liver to herniate into the thorax through the foramen of Bochdalek or Morgagni or through a traumatic rupture of the diaphragm. Anomalous positions of the liver may be associated with congenital cardiovascular disease, situs intervus, or asplenia.

CONTOUR VARIATIONS

The contour of the normal liver in the frontal projection is extremely variable, often reflecting impression by adjacent structures. The over-all outline is usually triangular, though a well-developed left lobe may give the liver a rectangular shape and a poorly developed left lobe may cause a globular appearance. The superior surface usually follows the contour of the diaphragm. There may be an impression of the right margin by the rib cage, and the inferior surface is often notched or indented near the porta hepatis. These normal variations must be distinguished from abnormalities of contour caused by extrinsic masses invading or displacing liver parenchyma and from marginal intrahepatic lesions. At times, this differential diagnosis is exceedingly difficult.

Scanning abnormalities occur late in the course of diffuse hepatic disease. Cirrhosis is a common example. Extraction of labeled colloidal particles is decreased; this is said to be secondary to decreased hepatic blood flow and to intrahepatic arteriovenous shunts. With progressive liver impairment the reticuloendothelial cells in the spleen and bone marrow take up increasing amounts of colloidal particles better than the liver. As uptake of radioactivity decreases, the liver scan loses its homogeneous appearance. The resulting patchy pattern reflects the huge statistical variation in count rate; it is not an image of the pathological process.

One of the most important applications of the liver scan is the differentiation of single or

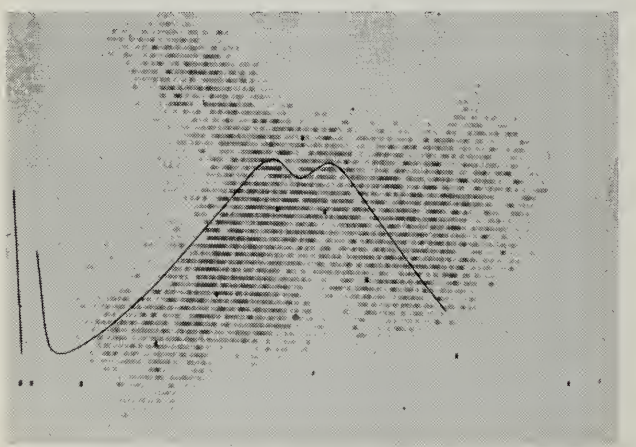


Figure 7. Amebic abscess. The scan demonstrates a large filling defect in the lateral aspect of the right lobe of the liver.

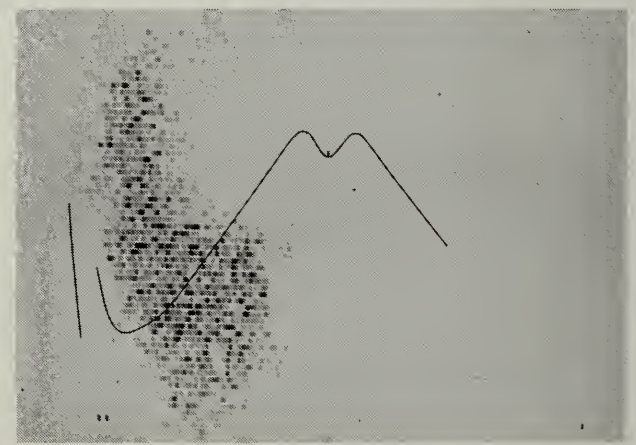


Figure 8. Liver abscess due to actinomycosis. The large filling defect is sharply circumscribed.

multiple focal hepatic lesions from diffuse liver disease. All focal lesions fail to concentrate radioactive materials and are seen as cold areas within the normally functioning hepatic parenchyma. The scanning process is not a means of making a microscopic diagnosis; the pathological entities causing focal filling defects cannot be distinguished from one another by the scan. The most frequent cause of intrahepatic filling defects are primary and metastatic malignancies such as hepatoma, metastatic carcinoma, and lymphoma; abscesses of pyogenic, amebic, tuberculus, or fungal etiologies; and cysts including polycystic disease. In a study that included 112 patients with proved hepatic metastases,[1] hepatomegaly was present in 52 per cent and abnormally small livers in 4 per cent. Solitary filling defects occurred in only 7 per cent; multiple filling defects, sometimes varying widely in size, were the rule and accounted for 69 per cent. Massive replacement was seen in 14 per cent. No filling defects were found in 10 per cent, but other instances of false negative hepatic scan may have been excluded because of inadequate follow-up.

BILIARY SCAN

Rose bengal I-131 is normally excreted by the liver through the biliary system into the duodenum. Identification of the isotope in the small intestine establishes patency of the biliary tract. If the isotope is not clearly seen in the small bowel at 20 minutes, a 4 to 6 hour delayed scan is indicated. The delayed scan commonly shows this material moving forward into the colon and gall bladder, with clearing of the liver and small bowel. In cases of complete extrahepatic obstruction the liver activity decreases very slowly and the kidneys are demonstrated. It has been pointed out[2] that in the difficult cases, differentiation of the type of jaundice breaks down even with this method; for example, in a case of hepatitis where there is enough parenchymal edema to cause a secondary obstruction of the biliary canaliculi.

The major limitation of liver scanning is the limited resolution of present equipment. In addition, present scanning agents localize in normal liver tissue, surrounding the cold abnormal areas in a sea of radioactivity. Phantom experiments have shown that demonstration of lesions less than 2.5 cm. in diameter is unlikely. Many hepatic metastases are smaller than this. Scanning techniques analogous to radiographic tomography may soon improve this situation.

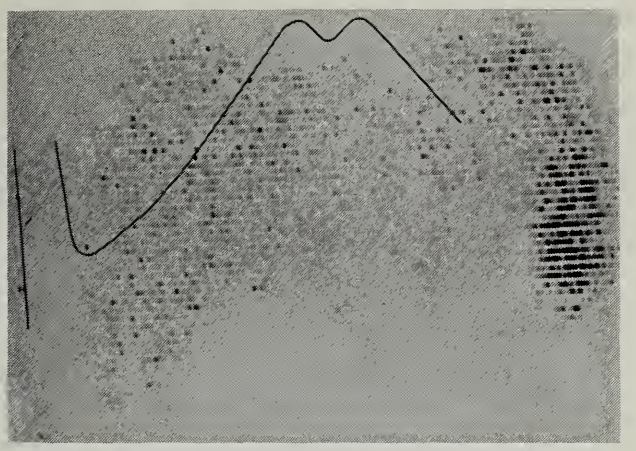


Figure 9. Laennec's cirrhosis. Diffuse decrease in concentration of radioactivity throughout the liver with prominent uptake in the spleen.

In diffuse hepatic parenchymal disease the uptake of radioactivity within the liver may be decreased enough to cause "statistical holes" that are frequently mistaken for real organic defects. The scintillation camera and new radiopharmaceuticals providing high counting rates will resolve this difficulty.

Liver scanning is now a widely accepted diagnostic technique. Although small lesions along the liver margin or deep within the liver substance may escape detection, hepatic photoscanning is a more accurate method of diagnosing space occupying hepatic lesions than any other single clinical test. The multiple views possible with the scintillation camera and newer radioisotope scanning agents promise to improve the accuracy and enhance the clinical value of the procedure. ★★★

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The Delta Pilot Project

ALFIO RAUSA, M.D.
Greenwood, Mississippi

Five counties in the northwest section of Mississippi are involved in the Delta Pilot Project. The geography, population characteristics and major health problems of the area are outlined, and the purposes and achievement of the program are discussed in detail.

When the contract for the Delta Pilot Project was initiated in 1966, the general objectives were:

1. to increase the application of existing health manpower and facilities to the health needs of the people in the Delta area,
2. to improve, supplement and strengthen existing health resources, including consultative backstopping by appropriate specialists and provision of actual hospital care or diagnostic services,
3. to assure access to health services for all Delta residents,
4. to recruit and train counterpart staff for the health professionals employed,
5. to recruit and train auxiliary health aides.

The five county area involved in the project is located in the northwest section of Mississippi, which is known as the Delta. In all, 18 counties comprise the Delta section, which is mostly flat and fertile land, much of which is used for planting cotton. The five project counties, Washington, Sunflower, Leflore, Carroll, and Montgomery, include an area of about 3,050 square miles. Only two counties, Washington and Leflore, have areas considered as urban. However, the entire project area is rural.

In the five county area, the following cities and towns are the county seats and locations for the respective health department headquarters. The population figures are from the 1960 U. S. census.

Greenville—41,502
Greenwood—20,436
Indianola—6,714
Winona—4,282
Carrollton—343

Health problems in the five Delta project counties include high infant mortality (68.3/1000 live births), high maternal mortality (9.6/10,000 live births), high tuberculosis case rate (244.8/100,000 population), high venereal disease case rate (177/100,000 population), and high rate of cardiovascular disease (ranks first in cause of death).

Factors contributing to the area's health problems are (1) shortages of health resources including doctors, dentists, nurses, and hospital beds; (2) substandard housing including deficient plumbing, overcrowding, and lack of water supply for many; (3) high accident rate due to low educational attainment, belief in superstitions, and hazardous surroundings; (4) lack of means of transportation for many; (5) high proportion of poverty stricken families and individuals.

It is helpful to look at several programs carried on by the State Board of Health for the control of chronic illnesses before discussing the new clinical services instituted in the Delta Pilot Project.

To assist the private physician in diagnosis and follow-up of heart disease, mainly rheumatic heart disease and congenital defects amenable to surgery, regional diagnostic and consultative case study services have been offered regularly at Regional Heart Clinic Centers. In the Delta Pilot Project counties such centers are located at Car-

rollton (Carroll County), Greenwood (Leflore County), and Indianola (Sunflower County).

The State Board of Health has been providing leadership for coordinated community planning and action to meet the public health problems posed by diabetes mellitus. It has cooperated with the Mississippi Diabetes Association in conducting surveys during Diabetes Week each year and is conducting programs to provide patient services, including distribution of insulin and supplies to the indigent, dietary counseling and instruction in the administration of insulin, to supplement physician care. It is also conducting a program of case finding by screening (with blood sugar determinations) high risk groups.

Leflore County Health Department and the Washington County Health Department are among the 81 county health departments over the state that are qualified under Medicare to offer Home Health Care which includes quality nursing care plus physical therapy to home-bound patients.

NURSING SERVICES

Finally, the local county health department under the supervision and guidance of the health officer and local physicians and through the work of the public health nurse, provides community nursing services to citizens of the state.

In the early part of 1966, a Greenwood physician approached the Mississippi State Board of Health with the idea of holding a special cardiovascular clinic for the indigent at the Leflore County Health Department. The idea was prompted by the large number of congestive heart failure patients who were discharged from the hospital and remained stable until the supply of drugs obtained there ran out. Then they returned to the hospital in congestive heart failure. There was a definite gap in the continuity of care for this type of patient.

The idea was accepted and in March 1966, the Special Cardio-Vascular Clinic became operational. Indigent cardio-vascular patients referred from the hospital and local physicians were followed at the Leflore County Health Department and appropriate medications were distributed to these patients free or at a token fee of 10 cents or 25 cents per month.

This clinic was the first of its kind in Mississippi. It was an experiment and its beginning was slow, so the program was expanded to care for diabetics in the Diabetes Program of the Division of Chronic Illness of the State Board of Health. More diabetics were seen than heart cases.

During the initial phase of the Delta Pilot Project, plans were made for strengthening and expanding the clinic to include diagnosis, treatment, and follow-up of patients with diabetes and heart conditions and also hypertension, arrythmias, and arthritis. Patients are referred to this clinic by the hospital, local physicians, the health officer, public health nurse, welfare department, and other local health and welfare agencies.

MEDICATIONS PROVIDED

Medications, such as antibiotics and anti-hypertensive-agents, aspirin, digitalis, diuretics, hypoglycemic drugs, both insulin and oral agents, and vitamins, are available for distribution to the medically indigent patients followed in these clinics. Funds for the purchase of these drugs have been made available from the Divisions of Chronic Illness Control and Preventable Disease Control of the Mississippi State Board of Health, Delta Pilot Project Funds, and from contributions (10 cents, 25 cents, $1 per month) from the patients themselves. The patients have accepted care and medications more readily since they have begun to contribute. No patient, however, is denied care or medications if he does not contribute.

In another experiment the Mississippi State Board of Health has contracted with a local practitioner in the rural Minter City area of Leflore County to hold a clinic at his office once a week for the purpose of rendering medical care to indigent patients referred to him by the public health nurses in the area. This general medical clinic, which includes diagnosis, treatment, and follow-up, is held every Thursday morning to coincide with the clinical hours of the nearby Rural Public Health Centers. The physician is supplied with the same type drugs available through the Special Cardio-Vascular Diabetes Clinic for free distribution to the indigent patients. He also supplies some drugs himself. All the laboratory tests available through the State Board of Health have been put at the physician's disposal for the patients referred to him from the Leflore County Health Department.

CLINIC ADVANTAGES

There are several advantages to this clinic. First, the patient is receiving needed medical care by the local physician in his community, medical care that the patient usually would not have sought because of financial embarrassment. Sec-

ond, the physician is being assisted, both financially and with nursing and laboratory services, in the rendering of medical care to the indigent population in his area. Third, the public health nurses in the area have a local physician with whom they feel free to consult and to whom they may refer their problem cases for evaluation, diagnosis, treatment, and follow-up.

After these clinical services were established, case finding was initiated. A Multi-phasic Screening Clinic Program by appointment for adults was begun and is now operational on a regular monthly schedule in all of the Delta Pilot Project counties. To date the screenees have been adults receiving welfare assistance and trainees in federal and state educational and vocational programs such as STAR, CEP, MDTA.

TABLE 1

CHRONIC DISEASES
CRITERIA FOR SCREENING TESTS

Screening Test	*Eligibility*	*Referral Levels*
1. Dip-Stick Urine	All ages	Positive for sugar and/or albumin
2a. TB Skin Test (Heaf test)	Ages 18-40	6 mm or more induration
2b. Chest X-Ray	Ages 35 and older or positive TB skin test	
3. Hearing (Audiometer)	All ages	Inability to hear two or more tones (either ear)
4a. Visual Acuity (Snellen Chart)	All ages	20/50 or poorer
4b. Pin Hole Occluder	Visual acuity less than 20/40	20/70 or poorer —ophthalmologist
5. Tonometry (Schiotz Tonometer)	35 years and older	Above 25 mm Hg
6. Blood Pressure	All ages	Ages 18-64 160/100 mm Hg; ages 65 180/100 mm Hg
7a. Blood Sugar	30 years and older	180 mg% if food or drink intake less than 1 hour; 160 mg% if between 1 and 2 hours; 130 mg% if over 2 hours
7b. VDRL	All ages	Reactive 1:1

In the case of the welfare recipients, about 150 appointments are mailed out at a time with approximately a 50 per cent turn-out. For a Multi-phasic Screening Clinic, the county health department staff is mobilized and is assisted by staff from the Division of Chronic Illness of the State Board of Health.

Table 1 shows the tests performed on a screenee who participates in a Multi-phasic Screening Program Clinic with relevant criteria as to eligibility and referral levels for each test.

ASSEMBLY LINE

Within the health department, testing stations, manned by public health personnel, are set up in sequence "assembly line" fashion. The prospective screenee enters the health department and reports to a registration desk for completion of identifying data on screening form and laboratory slips.

TABLE 2

REFERRAL RESOURCES
FOR CORRECTION OF DEFECTS FOUND
DURING MULTI-PHASIC SCREENING

Visual Defects: (including glaucoma)	Local ophthalmologists Local optometrists Lions Club Vocational Rehabilitation to the Blind Satellite Eye Clinic (Washington County Health Department, Greenville, or Leflore County Health Department, Greenwood) University Medical Center, Jackson V.A. Hospital, Jackson
Venereal Disease:	Private physician County Health Department
Tuberculosis:	Private physician County Health Department TB Sanatorium, Magee V.A. Hospital, Jackson
Chronic Diseases: (diabetes, hypertension, etc.)	Private physician Special Cardiovascular-Diabetic Clinic University Medical Center, Jackson V.A. Hospital, Jackson

He then proceeds to the first test station for a urine test (dip-stick) for sugar and albumin performed by a health aide. At the second station the screenee is either given TB skin test or 14×17 chest x-ray. At the third station a hearing test is performed with an audiometer by another aide or a public health nurse. At the fourth station visual

acuity is tested by an aide or public health nurse using the Snellen Chart. Any individual whose visual acuity is poorer than 20/40 will have his vision checked with the pin hole occluder. This test screens out persons with eye conditions requiring care by an ophthalmologist. At the fifth station public health nurses who have been trained in the use of a Schiotz tonometer, test for glaucoma. At the sixth station the screenee's blood pressure is checked by a public health nurse. At the seventh blood is drawn for a VDRL only if under 30 years of age or blood sugar and VDRL if over 30. All blood samples are sent to the State Board of Health Laboratory for appropriate analysis. All tests are performed under the direct and immediate supervision of a physician.

After a screenee has been to all stations, positive findings, with the exception of TB skin test, x-ray and blood tests, are communicated personally to each screenee by a counselor, usually the health officer or supervisory public health nurse, and he is urged to obtain medical care from one of the available resources depending on condition found and/or degree of indigency (Table 2).

Positive VDRL, blood sugar, TB skin test or chest x-ray are followed up at a later date by a personal home visit by the public health nurse or disease investigator.

The threefold purpose of this program is: health education, detection of unknown conditions, and referral for medical care.

By participating in a screening program, the individual learns the importance of routine, periodic evaluations for chronic diseases. Positive screenees, along with friends and families, learn about asymptomatic chronic disease in a personal direct way. Through the referral of persons who are in need of medical care to a physician, the screening procedure usually results in early treatment of previously unknown disease and prevention of disability.

Table 3 shows statistics for several Multiphasic Screening Clinic programs. Note the high incidence of glaucoma, hypertension and diabetes mellitis.

The Division of Chronic Illness of the State Board of Health, with the assistance of a project grant and assignment of an ophthalmologist from the Public Health Service, is developing a vision program for Mississippi. As part of this program a satellite eye clinic is operational at the Washington County Health Department in Greenville and the Leflore County Health Department in Greenwood. At these satellite eye clinics, which are being supported and assisted by the local ophthalmologist and staffed by ophthalmology residents from the University Medical Center and health department personnel, indigent patients receive out-patient eye services including diagnosis, treatment and follow-up. Also the program provides for surgical care in the local hospital and is receiving counseling as well as financial support from Vocational Rehabilitation of the Blind.

With the combined resources of the Division of Chronic Illness of the State Board of Health, Leflore County Health Department, Mississippi Arthritis Foundation and an internist from the University Medical Center, an Arthritis Clinic is planned at the Leflore County Health Department. ★★★

TABLE 3

STATISTICS FOR MULTI-PHASIC SCREENING PROGRAM

	Oct. 31	*Nov. 14*	*Nov. 21*	*Nov. 28*	*Total*
No. Screened	55	62	87	176	380
White	3	8	12	28	51
Non-White	52	54	75	148	329
Male	15	14	23	69	121
Female	40	48	65	107	260
Over 35 Yrs. of Age (but less than 50)	20	25	33	52	130
Over 50 Yrs. of Age	14	32	42	23	111
Tested for Visual Acuity	55	62	85	174	376
No. Not Able to See 20/40	15	20	23	32	90
Tested for Glaucoma (Tonometry)	36	56	78	77	247
Glaucoma Suspects	6	6	8	5	25
Found to Have Len Sclerosis	2	6	1	0	9
Found to Have Cataract	1	3	5	1	10
Found to Have Pterygium (Active)	1	6	5	7	19
No. Heaf Tested	29	41	75	167	312
Heaf Positive	12	13	7	46	78
Blood Pressure Taken	52	50	87	176	365
No. Found to Have B.P. (Greater Than 150/90)	14	17	26	33	90
Screened for Diabetes	39	59	78	5*	181
Blood Sugar Greater Than 130 mg%	14	6	10	1	31
VDRL Taken	50	60	82	165	357
Reactive VDRL	2	5	7	5	19
Oral Cytology	0	11	53	31	95

* STAR Trainees were screened for diabetes during National Diabetes Week, November 13-18.

Leflore County Health Department (38930)

Radiologic Seminar LXXXVII: Gas in the Biliary System

KENNETH O. WILLIAMS, M.D.
Brandon, Mississippi

THE PRESENCE OF GAS in the biliary system is invariably an abnormal finding which indicates the need for further study to determine its cause.

Biliary gas almost always indicates fistulous communication with the intestinal tract or very rarely with the bronchial tree. Regarding the usual sites of fistulous communication reported, the order of frequency is as follows: cholecystoduodenal 60 per cent; cholecystocolic 24 per cent; choledochoduodenal 10 per cent; cholecystogastric 6 per cent.

The majority of spontaneous biliary fistulas are due to erosion of a gallstone into the duodenum or transverse colon. If the stone is large and has entered the small bowel, it may cause obstruction in the region of the terminal ileum, the so-called gallstone ileus.

Gas can also enter the biliary tract because of a patulous sphincter of Oddi or from a surgical anastamosis between the intestinal tract and gallbladder.

A fistula can result from perforation of a duodenal ulcer or from erosion of a portion of the biliary system by a carcinoma.

Gas in the biliary tract is easily recognizable on the plain abdominal film by the presence of a Y shaped lucency in the right upper quadrant over the liver. The pattern represents the common duct and right and left hepatic ducts. The gallbladder also may become filled with gas as well as smaller biliary radicles.

If the accumulation of gas has been caused by a patulous sphincter of Oddi, barium will occasionally be seen to enter the common bile ducts,

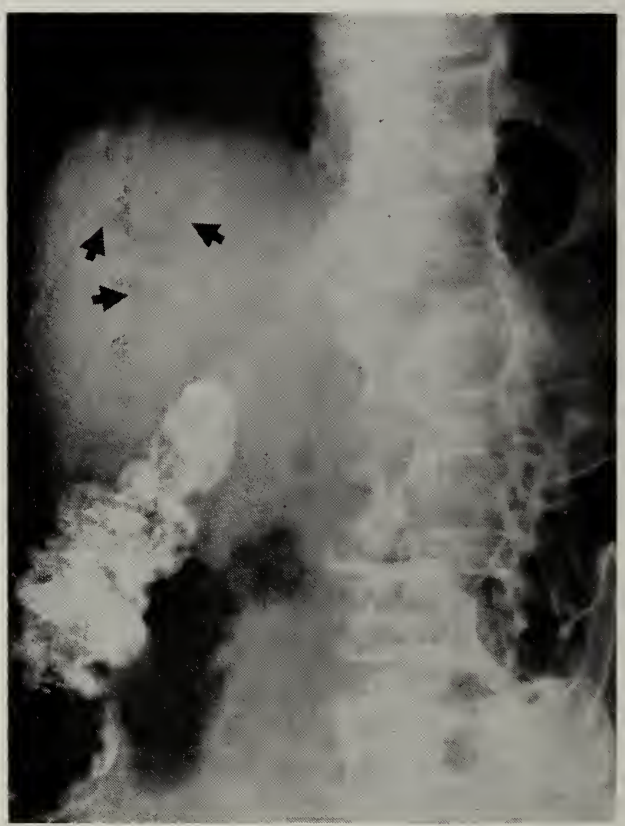


Figure 1. Oblique radiograph of the abdomen demonstrating radiolucent air shadows projected over the liver as indicated by arrows. The upper arms of the "Y" represent air in the right and left hepatic ducts and the lower limb is air in the common duct.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Rankin General Hospital.

during an upper gastrointestinal study, through the ampulla of Vater.

Emphysematous cholecystitis is a rare finding and is the result of infection of the gallbladder by gas forming bacilli causing an accumulation of gas in the gallbladder wall, its lumen, or surrounding tissues. This condition is usually found in diabetics who are poorly controlled. The causative organisms are almost invariably cl. welchii or e. coli. The roentgenographic pattern is that of multiple small gas bubbles outlining the gallbladder. Occasionally, an air-fluid level may be observed within the gallbladder lumen on an upright film of the abdomen.

Another entity causing gas in the right upper quadrant occurs following distention of the small bowel secondary to mesenteric thrombosis or devitalization of the bowel from other causes. The condition of the patient is always grave and the x-ray findings are the presence of fine linear lucent areas in the periphery of the liver with the gas being within portal veins. This resembles gas in the biliary tract, however, in the latter condition, the lucent bile ducts are located centrally rather than in the periphery of the liver.

The presented radiographs are those of a 70-year-old female with a long history of dyspepsia and right upper quadrant abdominal pain. As demonstrated on the obtained radiographs there was air in the biliary tree and reflux of barium into the biliary tree at the time of an upper G.I. series. This patient's fistula was thought to be due to erosion of a common duct stone into the duodenum. ★★★

Rankin General Hospital (39042)

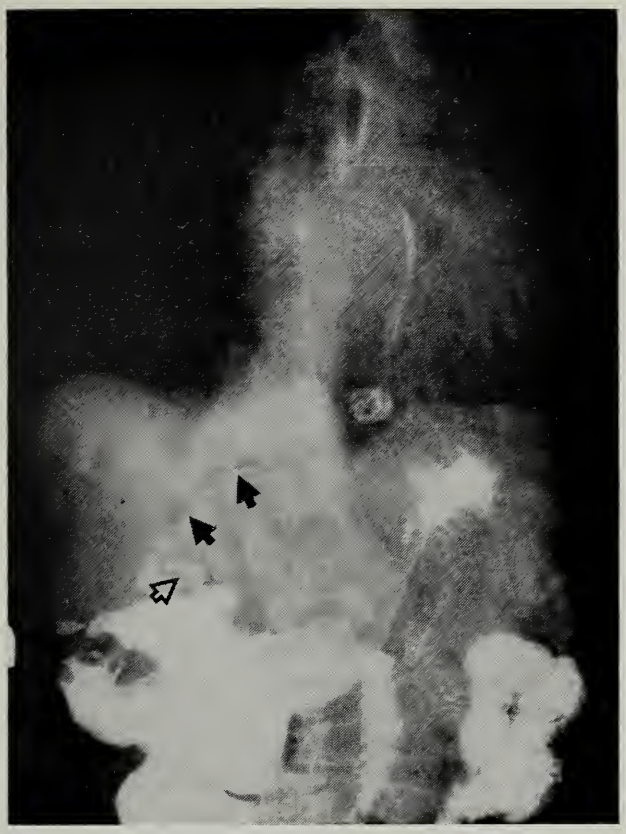


Figure 2. Radiograph obtained at time of upper G.I. series showing barium in the common duct (lower open arrow) and air in the left hepatic duct (upper closed arrows).

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PLENTY OF CENTS

My 8-year-old daughter answered the doorbell. No, her daddy wasn't in, she informed the caller. "He's at the hospital, doing an appendectomy."

"My," said the caller, "that's a big word for a little girl. Do you know what it means?"

"Sure I do," she answered promptly. "It means a hundred and fifty dollars."

—John Simmons, M.D.

A Transport System for Newborns With Respiratory Distress Syndrome

L. J. ARP, Ph.D.; R. E. DILLON;
MARY TOM LONG, M.D.; and C. L. BOATWRIGHT, M.D.
Blacksburg, Virginia

This paper describes an emergency air-ground transport system which has been used successfully to transport newborn infants with respiratory distress syndrome to the Roanoke Memorial Hospitals at Roanoke, Va. The special equipment which has been developed for ventilating the distressed newborn will not be available commercially for about one year. In an effort to make this equipment available immediately to physicians and the distressed infants, the Virginia Polytechnic Institute at Blacksburg, Va., has established an emergency air-ground transport system.

Respiratory distress in the newborn infant has been the largest single cause of death during the first week of life. About 17 per cent of all premature infants are affected by respiratory distress and about half of these die. About 25,000 infants expire each year in the United States.[1] This number represents between 30 per cent and 40 per cent of all newborn deaths.[2] Nearly half of the infants weighing less than 3½ pounds who now survive their respiratory distress may be mentally defective.[3] Dr. J. F. Lucey, writing in the January 1968, issue of "Hospital Practices," cites a study carried out at the Boston Lying-In Hospital where it was found that mortality among premature infants accounted for 71 per cent of all live-born infant deaths. The death rate in low birth weight infants was said to have shown ". . . no improvement in 21 years. . . ."

These grim statistics do more than suggest that high risk infants delivered in the average hospital in this country face great hazards. Indecision, uncertainty, and delay in resuscitation and treatment can result in irreversible anoxic tissue damage to the brain and other vital organs. The tragic results, many times ascribed to immaturity rather than anoxia, are known all too well. The wait-and-see, hands-off procedures, using oxygen and buffer therapy alone for treating respiratory distress, has been proved inadequate by experience.

Newborn intensive care nurseries are needed throughout the country. However, the specially trained personnel and new equipment designed specifically for the newborn infant are not generally available.

A dramatic decrease in infant morbidity and mortality rates has been achieved when nursing personnel, trained in the use of a special infant respirator, blood-gas, and physiological monitoring equipment, have been available.[4, 5] The average survival rate which can be expected for all infants weighing no more than 1,000 Gm. (2 pounds, 3 ounces) is about 10 per cent to 15 per cent.[6] These figures include those not afflicted with respiratory distress syndrome (R.D.S.).

In contrast, the survival rate for infants weighing no more than 1,000 Gm., with all 19 infants with respiratory distress, in a study by Arp *et al.*, was 31.7 per cent.[4, 5] Special equipment for treating the distressed infant provided a similar striking improvement in the survival rate for infants weighing no more than 1.500 Gm. (3 pounds, 5 ounces), where the normal survival rate for all infants in this weight group, including

those who were not in respiratory distress, is about 29.3 per cent.[6] The survival rate in the study by Arp *et al.*, for 42 infants, with all infants in respiratory distress, and weighing no more than 1,500 Gm., was 47.6 per cent.[4, 5]

It is unlikely that every hospital will be able to assemble and train a team of specialists to cope with the vexing problems associated with distressed newborns in the near future. In addition, the special infant respirators needed for the successful treatment of newborn respiratory distress syndrome will not be generally available for some time. Blood-gas analyzing and physiological monitoring equipment is expensive and requires skilled and specially trained nurses and/or technicians. Personnel with this specialized training are not readily available.

NURSES NECESSARY

The most difficult problem to solve, however, is that of convincing the nursing supervisors and the hospital administrators that each distressed newborn must have a graduate or licensed practical nurse for uninterrupted observation and attention as long as the physician carries the infant on the "critical" list. Each graduate or licensed practical nurse can manage two infants only after the patient is removed from the "critical" list.

In view of the requirements just outlined, it becomes clear that all hospitals cannot, in the near future, support and operate an intensive care nursery as it must be structured in order to reduce today's tragic infant morbidity and mortality rates. Intensive care nurseries must be established in population centers to provide the best medical care known today to the largest number of people. Infants from less populated areas will need to be transported to these specially staffed and equipped nurseries.

New transport systems must be devised to reduce the time and risks involved in moving the high risk patient to the centers before the patient becomes critically ill. Physicians will be called upon to make the decision to transfer patients long before they can be absolutely certain that the patients will not survive in the average hospital. The patients must be viable when they arrive at the intensive care nursery. New equip-



Figure 1. The VPI airplane.

ment and techniques cannot perform the miracle of restoring life to the dead.

A general plan has been outlined for supplying the best medical care known for the distressed newborn. This plan has been put into operation by the Virginia Polytechnic Institute, Blacksburg, Va., in cooperation with the Roanoke Memorial Hospitals, Roanoke, Va.

A twin engine Beechcraft airplane has been made available by Virginia Polytechnic Institute's president, Dr. T. Marshall Hahn, Jr., for transporting newborn infants with respiratory distress from hospitals lacking the needed specialized staff and equipment to the Intensive Care Nursery at the Roanoke Memorial Hospitals. The transport service described in the following pages will be available at the request of physicians and without charge until the new infant respirator becomes available commercially. The VPI airplane can land at any hard surfaced airport having a runway at least 2,800 feet long. The runway must be lighted for a night flight. The service may be obtained any time of the day or night that the airplane and infant respirators are not in use. To obtain this service or information, call Dr. L. J. Arp, 703-552-6574 or 703-552-1162, or R. E. Dillon, 703-552-2507.

AIRCRAFT EQUIPMENT

Figures 1, 2, and 3 show the airplane equipped with an Arp Infant Respirator, an Armstrong Servo-Control Incubator (supplied by Ohio Medical Products, Inc., 1400 E. Washington Ave., Madison, Wis.), a solid state static inverter to convert the airplane's 28 volt power supply to 117 volts (supplied by Communications Measurements Laboratory, Inc., 350 Leland Ave., Plainfield, N. J.), and a redundant oxygen supply.

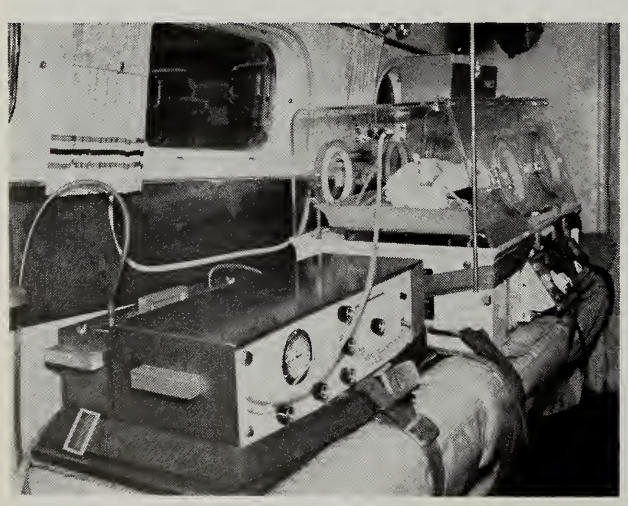


Figure 2. The Arp Infant Respirator and the Armstrong Servo-Control Incubator.

The volunteer flight crew includes the pilot, E. S. Warner; the co-pilot, Bill Byrne; Dr. L. J. Arp, professor of industrial engineering and Chairman, Division of Engineering Fundamentals, Virginia Polytechnic Institute; R. E. Dillon, instrument supervisor at VPI; and Dr. Mary Tom Long of the VPI Student Health Service, or Dr. C. L. Boatwright, a private practitioner in Blacksburg.

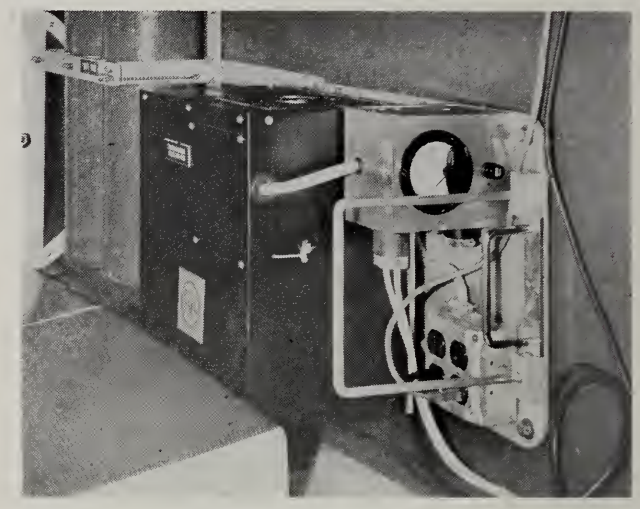


Figure 3. The C.M.L. Static Inverter Power Supply.

When a request is received for emergency air transportation for a distressed infant, the physician in charge of the transfer is requested to "stand-by" at the hospital with the infant in a warm incubator containing an atmosphere of 100 per cent oxygen. As the pilot approaches the pick-up point and a precise landing time becomes known, the control tower is requested to call the waiting physician to give him the landing time. If refueling is required, the completion time for this operation is passed on to the physician so that there is no delay in the transfer of the infant to the airplane system.

HANDLING INFANT

The infant in respiratory distress is transferred to the special holding and positioning fixture in the Armstrong Incubator. A restraining blanket is placed around the holding fixture as a safety belt for the infant. After respiratory assistance is started with the Arp Infant Respirator, using a nose mask as the patient-machine interface,[4, 5] the airplane is ready to take off for the Roanoke airport.

As the pilot nears the Roanoke airport and the arrival time becomes known, the control tower is requested to notify the Intensive Care Nursery at the Roanoke Memorial Hospitals of the arrival time. Figure 4 shows the specially equipped ambulance with redundant oxygen supply, a battery powered inverter to supply 117 volts, alternating current to power the incubator and the self-contained respirator which is dispatched with a nurse from the Intensive Care Nursery to meet the arriving patient.

TRANSFER TO AMBULANCE

The incubator is transferred from the airplane to the ambulance support system without interrupting respiratory assistance. The ambulance support system is then rolled up a special ramp into the waiting ambulance (as shown in Figure 5). The entire portable unit is then clamped securely in place to prevent any shifting of the unit during the trip from the airport to the hospital. Respiratory assistance remains uninterrupted as the infant is transferred from the ambulance, up the elevator, and into the Intensive Care Nursery.

Use of the battery powered respiratory support unit from the ambulance is not limited to the transfer of distressed infants from the airport to the hospital. This unit is used to supply respiratory support for infants during transfer from near-



Figure 4. The transport ambulance system.

by hospitals to the Intensive Care Nursery when it is either impossible or impractical to use the airplane. The portable unit is on stand-by in the delivery suite and in surgery for all deliveries and cesarean sections. The unit is also used to supply uninterrupted respiratory support while the infant is transported to the x-ray department, during radiological observations, and while using the x-ray intensifier. It has been observed that an interruption in respiratory support for even a minute or two can trigger irreversible changes in the patient which will cause death.

The degree of success in reducing newborn infant morbidity and mortality by supplying respiratory assistance is directly related to the condi-

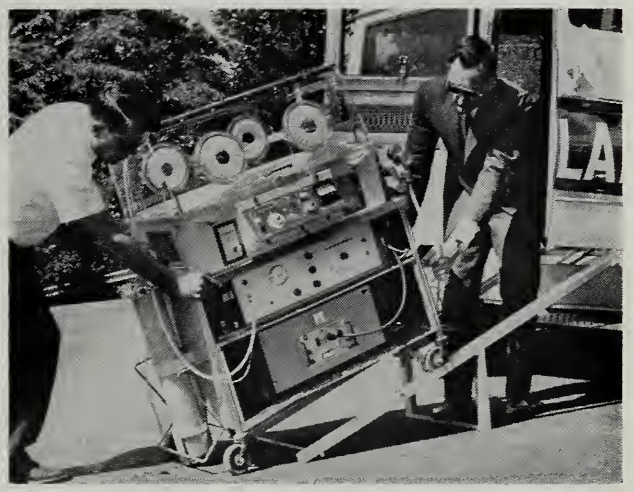


Figure 5. Respiratory support continues uninterrupted throughout transfer.

tion of the infant at the time he is provided that assistance. It has been found that the transfer is generally an exercise in utter futility if the referring physician delays in transferring the distressed infant until he is quite sure that the infant will not survive in the local hospital nursery. The concept of the absolute necessity for an early transfer and start of intensive and comprehensive support for the distressed infant has been most difficult to convey. The last-ditch stand by a physician using oxygen and buffer therapy has been proved by experience to be inadequate in many cases. No surgeon waits for a vermiform appendix to perforate before taking a patient into surgery. Likewise, the infant with R.D.S. has the best chance for survival if respiratory assistance is started immediately after the first clinical signs of trouble are observed.

KEY IS TEAMWORK

The integrated air-ground transport and support systems described in this paper have been used successfully. The key to this successful operation is teamwork. This teamwork can only be accomplished through education, training, and dedication to the idea that better treatment is possible and can become a reality through cooperative understanding and advanced planning. Once the hardware and support teams are available,

the only obstacles remaining in the path leading toward success are indecision and delays. ★★★

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COLD FEET

The old man had suffered a foot injury, but it was nothing compared with the injury to my nostrils when I removed his shoes. With all the delicacy I could muster, I asked him if he ever took time out to wash his feet.

"No," he said, "I never put 'em in water. The doctor tole me not to."

Baffled, I asked, "how did that happen?"

"Well, you see, I'd froze my feet, and my folks was just going to put 'em in some warm water; but the doctor said, real emphatic, 'Don't ever do that to feet like that.' "

"How long ago was that?"

"Oh, that was when I was a boy."

Fifty years late I prescribed warm water—and soap.

—M. B. Durfee, M.D.

Dr. James Marcus Taylor: Member First Mississippi State Board of Health

BEULAH M. PRICE
Corinth, Mississippi

The author, respected Mississippi historian, gives a brief biography and professional sketch of Dr. James Marcus Taylor of Corinth. Among his most distinguished accomplishments were membership on the first Mississippi State Board of Health and primary roles in the organization of the county and state medical societies of Mississippi.

On January 12, 1827, a baby boy was born in Jackson County, Georgia, who was destined to profoundly affect the history of organized medicine in the state of Mississippi.[1] The baby was named James Marcus Taylor.

When he was 12 years old James Marcus came with his father (John Taylor) to what is now Alcorn County. His elementary education was obtained at small, but good, private schools in the area.

He then alternated college study with farm work and read medicine for a time with his brother, Dr. W. A. Taylor. In 1850 James Marcus was graduated from Jefferson Medical College in Philadelphia.

In 1851 he married Miss Mary Cox in Griffin, Georgia. They soon settled in Rienzi, Mississippi, where he was living at the time of the outbreak of the Civil War.[2] Mrs. Taylor died in Dec., 1865, after the birth of their son, Charles Marcus.

Dr. Taylor entered the Confederate Army as a surgeon of the 26th Miss. Regiment. After the fall of Fort Donelson he was captured and remained a prisoner for several months. He then returned to Mississippi and in 1867 married Miss Sallie Murray (a cousin of his first wife).[3]

Dr. Taylor had seven children, four by his first wife and three by his second. He was a Methodist and a Mason. The doctor had a large and valuable medical and literary library and was said to be a "profound and earnest student on general, as well as medical topics."[4]

One aspect of Dr. Taylor's professional career of which he was proud was his service as preceptor to a number of medical students. Among these were Dr. Elvis McCrory, who was a Confederate surgeon; Dr. T. L. Patterson of Charleston, Missouri, Dr. W. H. McDougal and Dr. D. T. Price of Prentiss County, Dr. William O. Feemster of Lee County and Dr. N. C. Steele of Chattanooga. One pupil, Dr. M. A. Taylor, a nephew and namesake, practiced in Honey Grove, Texas. Others were Dr. [J. R.] Brewer who practiced in the Indian Territory, Dr. G. C. Chandler of Nacogdoches, Louisiana, Dr. B. M. Bishop (a son-in-law), Dr. Charles M. Taylor (a son) and a Dr. I. J. Bynum who practiced in "Middle Texas." It is said that most of these young men were received into Dr. Taylor's home and treated as part of his family.[5]

Dr. Taylor bought a Victorian Gothic house in Corinth in 1870 which still stands (May 1969) on the southeast corner of the intersection of Fillmore and Main Streets.[6] It is said that he established a large practice there and in the adjoining area. His was a general practice though "circumstances early forced him to devote special attention to surgery and the diseases . . . peculiar to women."[7]

In connection with Dr. Taylor's practice it is fitting to note here that when, in 1882, Mississippi

passed a new medical licensing act, that the doctor's application showed his choice as "Regular School of Practice." (Of 38 Alcorn County Medical licenses for 1882, which were checked, 18 doctors chose the Regular School of Practice; 13 that of Allopathic; one Botanic; one Scientific; three Eclectic; one stated "Specialist in Cancer and Ulcer; one stated "no one school exclusively.")[8]

Of special importance in Dr. Taylor's professional career was his interest and activities in medical organizations. He was chairman of the organizational meeting of the old Tishomingo County Medical Society and on July 2, 1860 was elected president.[9] During the war years the group became inactive and was not reorganized until 1870 at a meeting in Dr. Taylor's office in Corinth. The society was then called the Tishomingo District Medical Society to include Alcorn, Prentiss and Tishomingo Counties.[10]

In 1873 the physician became a member of the American Medical Association. He was one of the founders of the Mississippi State Medical Association and became president in 1874-75. (A glance at history will serve to remind one of the chaotic conditions which prevailed in the state at that time. A carpetbag government was in power in Mississippi, and serious civil strife occurred in a number of localities.) Dr. Taylor was a member of the Judicial Council of the M.S.M.A. in 1885-86.[11]

In the meantime, in 1877, Dr. Taylor had become a member of the first Miss. State Board of Health,[12] its organization being brought about in part by his earnest efforts."[13]

Another medical group in which Dr. Taylor was active was the Tri-State Medical Association, organized in 1880 (and which, in 1932, became the Mid-South Post Graduate Medical Assembly). Dr. Taylor was on the program at the third semi-annual session in November, 1881. His subject was "Antiseptic Surgery."[14]

Another facet of Dr. Taylor's medical career is his writings. It is said that he always believed in medical legislation and wrote many articles for medical journals while advocating the movement.[15] In the *First Annual Report of the Miss.* State Board of Health (1877), Dr. Taylor had an article: "City, County, State and National Boards of Health: Their Proper Organization, and Objects—Including the Registration of Marriages, Births, and Deaths." This subject had been assigned to him at the organizational meeting.

The detailed paper gives evidence of much thought and study and shows a familiarity with boards of health in other countries as well as the United States. Dr. Taylor said that only 13 states then (1877) had state boards of health and that the law (for the board in Mississippi) left much to be desired. He mentioned a bill he had prepared with the help of a Corinth lawyer, W. P. Curlee, which he proposed in lieu of the present law. He pointed out that local boards of health had existed in the larger towns and cities for a great while and necessity had forced some legislation for the protection of the people such as quarantine regulations, the abatement of nuisances, etc.

Dr. Taylor died at his home in Corinth Dec. 27, 1895, of apoplexy, being sick only one day.[16]

One cannot, of course, do justice to the varied activities of Dr. James Marcus Taylor in a few pages, such as these. Perhaps, however, a limited idea may be gained of some of his goals and how he tried to attain them. ★★★

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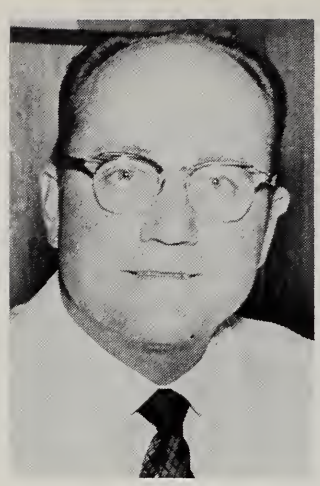
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The President Speaking

'A Matter of Equity'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

As a matter of just equity, physicians should have free access to tax shelter in professional corporations. Since the first Kintner plan in the early 1950's, the Internal Revenue Service and the Treasury Department have opposed this device. But to date, IRS has lost its court battles to deny physicians this benefit long enjoyed by the business community through conventional corporations.

Since 1965, most states have amended laws governing corporations and permitted physicians, attorneys, and other self-employed professional individuals to avail themselves to such tax benefits in order to provide a voluntary retirement plan. Yet, there is a cloud of uncertainty over the entire matter, because a single adverse decision by the United States Supreme Court could wipe out the benefit in every state. We urgently need for professional corporations to be recognized and sanctioned in the Internal Revenue Code.

In view of the many court decisions favoring physicians, it seems reasonable to expect that eventually the barriers will be completely removed and physicians will have free choice to form professional corporations for tax shelter. Those physicians already under a Keogh Plan would be allowed to discontinue it and move into a professional corporation.

Mississippi is one of the few states that does not have enabling laws to permit physicians to form professional corporations for tax shelter. Such a law was enacted at the last session of the State Legislature, but physicians and attorneys were excluded.

The Mississippi State Medical Association is on record, through action of the House of Delegates, in May of this year favoring a law to permit formation of this type corporation. Such a bill will be introduced in the Legislature next year. It is not too early for physicians to make their opinions known to their legislators.★★★

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EDITORIALS

The Delivery of Health Care: A System on Trial

I

THE DELIVERY SYSTEM which purveys medical care to Americans is on trial. Agencies of government at all levels are hacking away at it, while voluntary prepayment and insurance sources are introducing subtle influences upon it. And even its staunchest advocate, medical organization, is doing an exploratory laparotomy just to see if any pathology is present.

Nobody claims that our basically free choice delivery system is perfect. Indeed, its development has been characterized by change and innovation from days past when the practitioner was sometimes compensated with poultry and canned goods to the astonishing present with the complex procedure in the subsidized hospital covered by major medical insurance. But the system rests on bedrock of solid principles: The patient is free to choose, the practitioner may offer his services in a wide variety of clinical environments, and financing is broad, inclusive of almost every method and combination of putting together the means for care purchase.

Yet, from the President of the United States to the community-sponsored health project, there is talk of strain and weakness in the care delivery system. And while everybody talks about it, perhaps too few recognize with understanding exactly what pressures have been thrust upon it in the turbulent decade of the 1960's. Nor are we wanting for suggestions and proposals for resolving dilemmas, real and otherwise. These range from radical systems of social medicine through a spectrum of just about every alternative which the imagination can devise.

But as with Sir Winston Churchill's definition of free government, our health care delivery system may have profound faults, but it's the best anyone has come up with to date.

II

In a White House press conference conducted to introduce the newly appointed Assistant Secretary of Health, Education, and Welfare, Dr. Roger O. Egeberg, President Nixon stated that the nation has a major problem in health care. He described the difficulty as one of enough physicians and enough hospital beds to take care of the massive demand. In fact, he called it a crisis.

Said the President: "We face a massive crisis in this area and unless action is taken both administratively and legislatively to meet that crisis

within the next two or three years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

Since President Nixon's characterization of the problem was not precisely defined, it is difficult to say exactly what he had in mind about administrative and legislative action. But if recent actions of HEW officials count for anything, then vigorous administrative action has already been initiated.

What every American, including the President, must understand is that the circumstances under which medical care is rendered are not necessarily those of medicine's choosing or devising. The care climate is a product of the total social, political, and cultural environment. No thinking person would say that hospitals have deliberately inflicted upon themselves horrendous costs problems. Certainly, physicians clamoring for associates in practice have not willed a shortage of medical manpower.

The cold truth of the matter is that virtually every system of service, almost every good that is purchased, and every law that is obeyed are what society wants them to be. To those who choose to ignore this simple axiom of human nature and charge that American medicine would turn back the clock, we say that a science which has moved itself a century ahead in a generation of time with the therapeutic results to prove it is much more of a victim than an architect.

III

Dr. Ernest B. Howard, the astute executive vice president of the American Medical Association, has observed that our biggest problems are manpower and costs. In a logical extension of this realistic view, President James L. Royals of the Mississippi State Medical Association calls attention to four "P's": Purchasing power, people, and progress.

Dr. Royals has noted with circumspection that government programs of care financing have significantly expanded the purchasing base, perhaps to as many as 40 million Americans in five years. He points out that with the growth of population, there are obviously more consumers of medical care. And topping these off, medicine progressively has more to offer in services with the forward thrust of progress.

If Dr. Royals has had a theme during the first third of his presidency, it has been peer review with medicine as the master of its own house. He calls for fee review committees at the local society level whose objective function would be to assure fair treatment of the financing mechanism, private or public, and just compensation for professional services rendered by the physician. He speaks with firmness about the occasional aberrant quantity in the physician equation who should and must answer to his peers.

In advancing the case for medical society-sponsored peer and utilization review, Dr. Royals has said that "we should make responsible judgments and be able to prove ourselves worthy to have them accepted."

IV

The American medical care delivery system is pluralistic, not monolithic. A brief moment of reflection can demonstrate that the monolith is what physicians have consistently opposed, be it the monolith of government, of institutions, or a specific force and idea of society. And while the give-and-take in pluralism sometimes means more give than take, the ultimate evils of inflexibility, circumscribed choice, and single-system domination are at least minimized.



"I didn't say you were a hypochondriac. I merely said, not many people have monogrammed pills of their very own."

The first Medihaler was developed for the physician-inventor's own child.

The improved model you prescribe today is still made with the same painstaking devotion.

When your patient is in the grip of bronchospasm and reaches for his Medihaler, it must work. Not sometimes. Not most of the time. *Always.*

This is the ideal of perfection which has motivated the constant process of improvement of Riker's Medihaler.

Since its invention in 1956—when a Riker physician developed the Medihaler because of his determination to make better treatment available for his own asthmatic child—Riker has pioneered just about every significant forward step in bronchodilator aerosol therapy.

Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

Riker was first to formulate medication in a non-irritating, non-alcoholic vehicle.

Riker pioneered pre-grinding of the medication to 1-5 micron size, assuring maximum distribution to the distal bronchioles for greater topical effectiveness with less systemic action. (Oddly, even today not all competitors have adopted these two advances.)

Add to these advantages a quality control system involving 168 physical measurements and chemical tests, plus not one but two test firings on every single unit leaving the plant, and you can readily see why there is no more dependable relief for bronchospasm than your prescription for Duo-Medihaler or Medihaler-Iso.

Please see next page for complete prescribing information.

Medihaler-Iso®
(isoproterenol sulfate)



Duo-Medihaler®
isoproterenol HCl (4mg./cc.)
phenylephrine bitartrate (6mg./cc.)

Riker Laboratories, Northridge, California 91324

The Riker Representative in your area is: Dalton Johnson

SUMMARY OF PRESCRIBING INFORMATION

DUO-MEDIHALER®

(isoproterenol hydrochloride and phenylephrine bitartrate)

Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Northridge, Calif. 91324

Dr. Egeberg, who cannot be described as a professed conservative, appears to recognize this when he said that "what essentially is at issue is the transformation of vast potentialities and rapidly developing medical technologies into, for the first time in the nation's history, a purposeful, well-articulated, well-understood system for the delivery of health services.

"We do not speak of one monolithic system," Dr. Egeberg said, "but rather in keeping with the nation's traditions and its strength, a pluralistic system, infused with the unity of purpose and dedicated to a single national goal, the best possible health care for all."

If the Assistant Secretary's methodologies can match the apparent high purposes of his words, then there is hope that the pressures and strains can be relieved without undesirably supplanting a good system which society, not medicine, has put on trial.

Dr. Egeberg's boss, HEW Secretary Robert H. Finch, appears as a curious paradox at times. On the one hand, he appoints Walter McNerney to chair a committee on the delivery of health care, while on the other, he turns thumbs down on European systems. Secretary Finch dismissed Scandinavian delivery systems by pointing out that there are fewer people in Sweden and Norway than there are in Los Angeles County and that he doesn't think "we are ready for anything of that kind in this country."

For some, there are only solutions of doctrinaire governmental approaches. Others would permit a little wiggle room, but most are, in the final analysis, realistic about a system that works, however pressured and strained by artificially superimposed factors.

One profound error in assessing the delivery of medical care in the United States has been to tie all shortcomings to financing. The real test, it seems logical to believe, is the *orientation* of the system toward accessibility, flexibility, and individuality. The rigid monolith, however ideally conceived, simply cannot deliver the Utopian promise of all the health care of the highest quality in a quantity adequate for every need.

It would be absurd to orient health care to a single segment of the population such as the poor or the rich, because this begins the monolithic structure. A true pluralistic delivery system demands equal versatility in every branching pipeline to the differing strata of society. We have only to examine the generous providing of gratuitous services and the dedication of the profession to helping those who need help to realize that this is the desire and concern of the physician.

Of course, we have problems, but in the real sense, society has put itself—not the delivery system—on trial.—R.B.K.

Moon Bugs Are No Laughing Matter

The great moon bug issue failed to catch the public fancy, because Astronauts Armstrong and Aldrin bouncing around on the moon is a tough act to follow. But there was serious scientific debate about the nature and extent of isolation for the returning astronauts and their equipment.

The isolation period established was 21 days following exposure to the lunar environment. A number of respected biologists and physicians said that this wasn't long enough. Examples of earth bugs requiring up to a year's gestation were given. Still others said that no matter how thorough the isolation techniques in the Lunar Receiving Laboratory at Houston, there is no containing micro-organisms.

Dr. Charles R. Berry of NASA, the astronauts' chief physician, says that the Apollo 11 crew members should be watched the rest of their lives to make certain that moon bugs haven't affected them.

All of this is in the realm of exobiology, the science of extraterrestial life forms. Some wags say that this is the only discipline of science with no content, but if all its disciples do is prove their case in the negative, then they shall have performed a genuine scientific service. It is reasonable to anticipate the day when exobiological considerations will assume proportions of great importance as space voyages go deeper into the universe. A real moon bug would not be a laughing matter.—R.B.K.

Changing Views on Therapeutic Abortions

This business of abortion being a dirty word with dirtier connotations is changing. State legislatures have not only taken a hard look at century-old statutes on abortion but they are doing something about them. In 1967, the American Medical Association revised its policy position on abortion. What is surprising is that the policy which was revised was that adopted in 1871.

Abortion has many faces: The moral-spiritual-religious aspect, medical and scientific considerations, and the orientation of society to custom, usage, and mores. The divergent and hardened views of major religious faiths on the subject sometimes leaves society as confused as it is adamant. Clearly, the subject has become equated with the ultimate evil in sex, a near-insoluble issue in morality, a legal nightmare, and for physicians, an issue of dubious merit in the light of what society says and does.

Since something had to give, it did. The first consideration, it goes without saying, is that illicit or criminal abortion has been, is now, and always will be reprehensible and totally contrary to reason, morality, and science. Nobody in his right mind is debating this.

The real issue is therapeutic abortion and the circumstances under which it may be undertaken. Just two short years ago, 45 states, including Mississippi, permitted termination of pregnancy only to save or preserve the *life* of the mother. The five remaining states and the District of Columbia permitted the procedure to protect the *health and safety* of the mother. A number of states allowed abortion where the pregnancy was attributable to rape or incest.

The AMA position is one of three separate and two interrelated stipulations:

—That there is documented medical evidence that continuation of the pregnancy may threaten the life or health of the mother, or

—That there is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

—That there is documented medical evidence that continuation of the pregnancy, resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of the patient; and

—Two physicians, chosen because of their recognized professional competence, have examined the patient and have concurred in writing, and

—The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

There are two footnotes to the policy. First, it is urgent and necessary that the patient be fully advised of medical implications inherent in the procedure. In brief, she and her family must be in the position to give informed consent. Second, it is important for physicians, regardless of their personal convictions on the issue, to appreciate that it is consistent, under AMA policy, with the *Principles of Medical Ethics* for them to give medical information and guidance to state legislatures desiring to consider revision of such laws.

Two years have made a difference on the legal scene in the revision of abortion laws, and this suggests that society may be changing its mind about meeting an urgent problem. After all, *before* these changes were undertaken, it was a fact of life that at least 10,000 pregnancies were ter-

minated each year by physicians in hospitals with the full knowledge of their peers.

There are now only 30 states with the "save or preserve" life limitation, a reduction of one-third. And by sharp contrast, this is the new scoreboard on state abortion laws as of June 1969:

—Permitted to preserve the life of the mother or to prevent serious bodily injury, one state.

—Permitted to preserve the life or health of the mother, four states.

—Permitted to secure the safety of the mother, one state.

—Permitted to preserve the physical or mental health of the mother, eight states.

—Permitted to prevent birth of a child with grave physical or mental defect or deformity, eight states.

—Permitted where pregnancy is the result of rape or incest, 10 states.

In 1968, the state medical association's House of Delegates officially recognized the revised AMA policy on abortion and commended it to the association when examining possible revisions in the law. There is now quiet, thoughtful discussion about state laws governing abortion in Mississippi. We can reasonably anticipate that this will be a matter before the 1970 regular session of the legislature.—R.B.K.

Robins and Richmond: Education Hallmark

A leading personality in the pharmaceutical manufacturing industry and a little-known university are very much in the news. E. Claiborne Robins, president of A. H. Robins Co., has made the largest single gift in the history of American education to the University of Richmond, a cool $50 million. Mr. Robins is a Richmond alumnus, as was his celebrated father and now his two children.

The gift consisted of 1,030,000 shares in the former family pharmaceutical company worth $40 million and a cash challenge grant of $10 million to be matched on a dollar-for-dollar basis by a subscription campaign. Most 100-year-old endowment funds of leading universities fail to top this single gesture of unprecedented philanthropy.

Mr. Robins has emphasized that he is interested in quality, not quantity. He doesn't want the money used to make Richmond another sprawling academic monster. But he wisely gave the money with no strings attached, and the trustees of the university are free to use it as they choose.

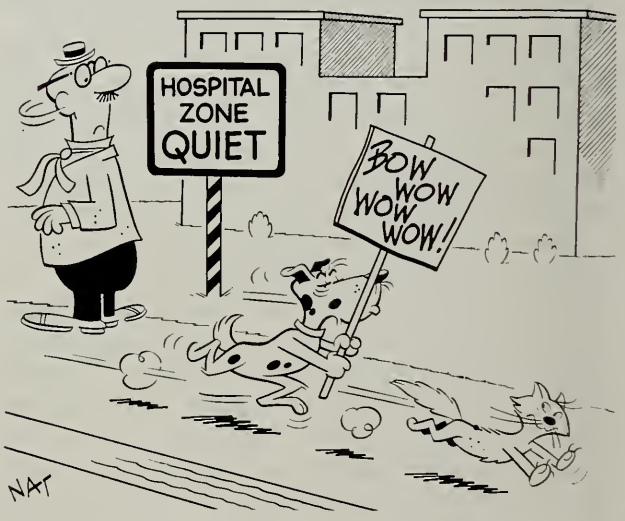
This is an example of free enterprise in action, because no program of government could possibly have assisted the University of Richmond to this extent in a century. Of course, it may be said, neither did it help any other university. But here is an example of private initiative growing out of free enterprise which our ethical pharmaceutical industry personifies. Now, let others go and do likewise.—R.B.K.

A Choice for the Physician

Separate billing by physicians whose practice is hospital-oriented seems to have reached a plateau, at least according to the findings of one major specialty. The American College of Radiology has announced that a firm two-thirds of radiologists bill separately in whole or part and that there is no apparent tendency for the practice to expand.

The latest ACR studies show that 47.3 per cent of radiologists in hospitals bill all services separately and another 21 per cent send their own statements for at least part of their services. The move toward separate billing by radiologists seems, according to the survey, to have stabilized.

The growing mountains of paperwork, medicine's 20th century headache, may be partly responsible. Obviously, it's easier and much less ex-



pensive to have the hospital's front office take care of the chore. Some few radiologists have tried separate billing only to revert to hospital billing.

Dr. J. Frank Walker of Atlanta, president of ACR, says that "from information available from the 1969 data, it is apparent that there is a tendency for radiologists to polarize at the two extremes; they separate bill all patients at all hospitals or they do no separate billing at all."

As Dr. Walker further observed, it is important for the physician, *not* the hospital, to make the decision on separate billing. This is especially pertinent to the experience of some physicians in hospitals where prerogatives of practice are eroded away by administrative controls. To circumscribe the physician with a maze of administrative regulations and limitations and still look to him to exercise professional judgment and personal responsibility puts him in an untenable posture. After all, it is the physician and not the hospital who practices medicine.—R.B.K.

POSTGRADUATE CALENDAR

PRACTICAL MANAGEMENT OF VASCULAR DISEASE

University Medical Center, Jackson
September 25, 1969, beginning at 9:00 a.m.

Sponsored by the University of Mississippi School of Medicine Postgraduate Education Committee and the Department of Surgery

Participants:

W. O. Barnett, M.D., professor of surgery, University Medical Center

Carlos M. Chavez, M.D., assistant professor of surgery, University Medical Center

Julian H. Conn, M.D., clinical professor of surgery, University Medical Center

William R. Fain, M.D., clinical assistant professor of surgery, University Medical Center

James D. Hardy, M.D., professor of surgery and chairman of the department, University Medical Center

Thomas A. Kilgore, M.D., clinical instructor in surgery, University Medical Center

Martin H. McMullan, M.D., resident, University Medical Center

William A. Neely, M.D., associate professor of surgery, University Medical Center

Frank C. Spencer, M.D., professor of surgery and chairman of the department, New York University School of Medicine

Hilary H. Timmis, M.D., associate professor of surgery, University Medical Center

Henry B. Tyler, M.D., clinical instructor in surgery, University Medical Center

Thursday Morning

Approaches and Techniques for Angiography
Dr. Chavez

The Management of Arterial Trauma
Dr. Spencer

Aorto-iliac Occlusive Disease
Dr. Neely

Abdominal Aortic Aneurysm
Dr. Hardy

Femoral-popliteal-occlusive Disease
Dr. Conn

Small Vessel Ischemia of the Extremities
Dr. Tyler

Arterial Lesions of the Upper Extremity
Dr. McMullan

Thursday Afternoon

Arterial Embolism
Dr. Barnett

Early and Late Complications of Vascular Surgery
Dr. Fain

Pulmonary Embolism
Dr. Timmis

Ischemia of Abdominal Viscera
Dr. Kilgore

Myocardial Ischemia and Its Complications —Surgical Approaches
Dr. Spencer

Panel Discussion—Questions and Answers Relating to Vascular Problems
Dr. Spencer, Moderator
Dr. Hardy
Dr. Conn

CIRCUIT COURSES

Northern Circuit

Tupelo—September 16, October 21, November 18, North Mississippi Medical Center, 7 p.m.

Greenwood—October 23, October 30, November 6, Greenwood Leflore Hospital, 7 p.m.

Session 1—Peripheral Vascular Disease
Angiograms, Dr. Hugh C. McLeod
Surgical Approach, Dr. Thomas L. Kilgore

POSTGRADUATE CALENDAR / Cont.

Session 2—Diagnosis and Management of Rheumatoid Arthritis, Dr. Thomas E. Wilson, III
Anatomical Factors in Gall Bladder Surgery, Dr. Edward M. Lowicki
Session 3—The Diagnosis of Cardiac Disease
In Children, Dr. David Watson
In Adults, Dr. Patrick Lehan

SOUTHWEST CIRCUIT

McCOMB—October 7, Southwest Mississippi General Hospital, 7 p.m.
NATCHEZ—October 21, Jefferson Davis Memorial Hospital
Session 1—Renal Trauma
Management of Traumatic Renal Shutdown, Dr. John Bower
Surgical Aspects of Urinary Tract Trauma, Dr. W. Lamar Weems

FUTURE CALENDAR

September 16, 1969
CIRCUIT COURSE, TUPELO

September 25
PRACTICAL MANAGEMENT OF VASCULAR DISEASE

October 6-10
PEDIATRIC INTENSIVE COURSE

October 7
CIRCUIT COURSE, McCOMB

October 13-17
ELECTROCARDIOGRAPHY INTENSIVE COURSE

October 21
CIRCUIT COURSE, NATCHEZ
CIRCUIT COURSE, TUPELO

October 23
CIRCUIT COURSE, GREENWOOD

October 30
CIRCUIT COURSE, GREENWOOD

November 3-7
GASTROINTESTINAL DISORDERS INTENSIVE COURSE

November 6
CIRCUIT COURSE, GREENWOOD

November 13
CURRENT CONCEPTS OF GYNECOLOGIC CANCER

November 18
CIRCUIT COURSE, TUPELO

January 6, 1970
CIRCUIT COURSE, McCOMB

January 8
CIRCUIT COURSE, HATTIESBURG

January 27
CIRCUIT COURSE, COLUMBUS

February 5
CIRCUIT COURSE, HATTIESBURG

February 17
CIRCUIT COURSE, NATCHEZ

February 24
CIRCUIT COURSE, COLUMBUS

March 12
CIRCUIT COURSE, HATTIESBURG

April 1-3
CARDIOVASCULAR SEMINAR

April 7
CIRCUIT COURSE, McCOMB

April 21
CIRCUIT COURSE, NATCHEZ

April 28
CIRCUIT COURSE, COLUMBUS

May 11-14
MISSISSIPPI STATE MEDICAL ASSOCIATION

PERSONALS

CLYDE R. ALLEN, JR.; JAMES N. McLEOD, III; BERT E. BRADFORD; WILLIAM A. CAUSEY; and JAMES J. HUDGINS, all of Jackson, have begun specialty training at the University Hospital in Jackson. The five new residents all got their M.D. degrees from the University of Mississippi School of Medicine.

GEORGE L. ARRINGTON, JR. of Meridian has announced the opening of his office at 1413 22nd Avenue for the practice of otorhinolaryngology. Dr. Arrington is certified by the American Board of Otolaryngology.

WILLIAM D. BRIDGES of Pascagoula announces the opening of his office for the practice of psychiatry at the Medical Center on Hospital Drive.

A. E. Brown of Columbus announces the opening of his office at 825 2nd Avenue North.

Curtis W. Caine of Jackson was elected to a one-year term as president of the Flying Physician's Association during the organization's 15th annual meeting in New York.

Rex W. Collins of Laurel has opened his new office at 1203 Jefferson Street. Dr. Collins will limit his practice to diseases and cancer of the skin.

John B. Ederington of Vicksburg has become associated with Drs. Edley H. Jones and Chester W. Masterson in the Eye, Ear, Nose and Throat Clinic in the First National Bank Building. Dr. Ederington will limit his practice to ophthalmology.

David Ellis of New Albany will serve as YWCA chairman for Union County and will spearhead the campaign for the Y-Teen Golden Anniversary Fund drive and for additional adult and teenage members.

Harry Fulcher, Jr. of Jackson has joined the Posey-Stephenson-Fyke Clinic in Jackson at 746 Manship Street. He limits his practice to internal medicine.

Wendell N. Gilbert of Newton began practice there July 14 in the building at 109 School Street, formerly the Todd Clinic. Dr. Gilbert, a graduate of the University of Mississippi School of Medicine, also joined the staff of the Newton Hospital.

William G. Giles of Hattiesburg has joined Dr. Edward A. Attix in the practice of orthopaedic surgery at the Medical Plaza.

Douglas Godfrey of Jackson spoke on burns to the District 15 nurses at a recent meeting.

William H. Goodloe, Jr. has joined the practice of Charles M. Head, at room 402, Medical Towers, Jackson. They limit their practice to obstetrics and gynecology.

Mack Gorton has returned to Belzoni to practice with Drs. T. J. Barkley and W. C. Moore in the Belzoni Clinic.

James C. Graham of Enterprise gave the commencement address to the practical nurses class at Jones County Junior College.

J. M. Griffith of Columbus has been elected president of the medical staff for Lowndes General Hospital, the new 144-bed facility to open in August. Other officers are J. H. Holleman, vice president, and Frank J. Baird, secretary-treasurer.



PATRICK M. FLANAGAN and CLYDE J. LEWIS, JR. have become associated with the Ball-Pittman Clinic for Women at 1820 Hospital Drive, Jackson. They will limit their practice to obstetrics and gynecology.

L. J. HAMMETT and L. H. DAY have joined the staff of the Ear, Nose and Throat Clinic at the Medical Plaza in Hattiesburg. They will occupy suite 101 with Dr. James E. Harris.

STANLEY H. HARTNESS has moved to Kosciusko where he will be associated with Drs. Paul Mink, Coleman Pickle, and R. N. Gilliland in the practice of medicine at the Attala Medical Clinic.

DOUGLAS B. HAYNES, JR. has associated with Drs. Robert R. McGee and Walter T. Taylor in the practice of internal medicine and hematology at the Medical Arts Building, Clarksdale.

JACK C. HOOVER of Pascagoula has announced the opening of his office for the practice of obstetrics and gynecology at 224 S. Pascagoula.

JAMES H. JONES of Columbia has moved his family to Houston, Tex., where he will pursue a radiology residency at the University of Texas Medical School.

W. R. LOCKWOOD of Jackson, UMC assistant professor of medicine, attended a pathobiology conference in Aspen, Colo., Aug. 1-15.

ANDREW K. MARTINOLICH, JR. of Bay St. Louis has discontinued his practice there and will take a radiology residency at the Charity Hospital in New Orleans.

ANDIN C. MCLEOD has returned to the University of Southern Mississippi as physician in the department of student health services. A former USM star gridder, Dr. McLeod will go to Memphis in January to complete an orthopedic residency.

SHELBY W. MITCHELL, JOHN M. MCRAE, JR., and R. L. THOMPSON, all of Laurel, have been named members of the Jones County Home Health Service Advisory Committee. The committee, which will meet quarterly, was created to study ways to improve the Service.

CARL J. MORAN, JR. has opened his office for the general practice of medicine in Fayette. The UMC graduate will practice in the office building with Dr. Elmo Gabbert.

WILLIAM A. NEELY and TETSUZO AKUTSU, both of the University Medical Center in Jackson, were featured speakers at a mid-summer meeting of the Mississippi Society of Professional Engineers in Biloxi. They spoke on engineers in medicine.

S. RAY PATE of Jackson has not opened permanent offices in the Messina-Williams Clinic at Vicksburg but he will see patients there on Thursdays only. Dr. Pate practices psychiatry in Jackson at 440 East Woodrow Wilson.

CHARLES A. RAY, III has joined the staff of the Rush Medical Group in Meridian as a general practitioner and surgeon. Dr. Ray earned his M.D. degree from the University of Mississippi School of Medicine in 1965.

ROBERT R. RESTER has become associated with CURTIS D. ROBERTS in family practice at the McLaurin Medical Center, Jackson.

JOE C. SCOGGIN of Jackson has opened his office at 706 Medical Towers, Jackson, for the practice of general psychiatry. Dr. Scoggin has special interest in the psychiatric treatment of children.

OMAR SIMMONS of Newton will serve as chairman for the Newton County Y-Teen Golden Anniversary fund and membership drive.

CHARLES W. TURNER has joined FRANCIS R. CONN in the practice of orthopaedic surgery at the Hattiesburg Bone and Joint Clinic.

ANTONIO G. VESA has announced the opening of his office at 210 W. Howard Ave., Biloxi, for the practice of ophthalmology.

WILLIS WALKER, JR. of Hattiesburg spoke at the Conference on Drug Abuse on the University of Southern Mississippi campus in July. He talked about the medical and health consequences of drug abuse.

S. JOBE WILDER announces his association with THOMAS W. TALKINGTON for the practice of orthopedic surgery at 464 Hinds Professional Building, Jackson.

DAVID B. WILSON of Jackson has been installed president of the Jackson Rotary Club for the 1969-70 term.

They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride **Endurets®** prolonged-action tablets

Geigy

NEW MEMBERS

The following physician has been elected to membership by his component Medical Society in the Mississippi State Medical Association and the American Medical Association.

EVANS, JOHN ELLIS, Vicksburg. Born Vicksburg, Miss., Sept. 10, 1934; M.D., Loma Linda University School of Medicine, Loma Linda, Los Angeles, Calif., 1962; interned White Memorial Hospital, Los Angeles, Calif., one year; orthopaedic surgery residency, same, June, 1963-April, 1966, Keesler Air Force Base Hospital, Biloxi, Miss., April, 1966-April, 1968, White Memorial Hospital, Los Angeles, Calif., April, 1968-Nov., 1968; elected July 8, 1969 by West Mississippi Medical Society.

UMC and MSU Offer Ambulance Driver Course

Under a contract with Mississippi State University, the University Medical Center will offer a series of six three-day courses on emergency care techniques for ambulance attendants, policemen, firemen, and other appropriate nonmedical personnel beginning in September.

The training program is part of Project CARE (Coordinating Accident Rescue Endeavor) funded by a grant from the National Highway Safety Bureau to the MSU Engineering and Industrial Research Station and covering 38 counties within a 50 mile radius of Greenwood, Jackson, and Hattiesburg.

The content will include such material as control of bleeding, cardiopulmonary resuscitation using American Heart Association techniques and manikins, emergency management of childbirth, fractures, poisoning, burns, water accidents, and electrical shock, and rescue from buildings and vehicles. Dr. W. A. Neely, associate professor of surgery, is course coordinator. School of Medicine faculty and residents will serve as instructors.

Announcement of the program will go out to mayors, sheriffs, fire chiefs, ambulance firm owners, and other similar individuals within the near future. Initially, the invitation will reach only the 38 counties but may be extended to the rest of the state if places remain in the classes.

MSMA Life Group Gets Bonus

The Mississippi State Medical Association's group life insurance program will soon offer participating members a new bonus, according to Thomas E. Yates, III, of Jackson, program administrator. Yates said that favorable experience had resulted in the programs offering 20 per cent additional benefits for the same premium.

Begun in 1962, the life coverage has been progressively improved. Yates said that more than $5.5 million protection is in force for participating members of the association.

With no change in premiums, coverage is being expanded by a fifth on all contracts. Coverage is available in packages ranging from $10,000 to $40,000. The bonus automatically raises protection by 20 per cent, now making the range $12,000 to $48,000, Yates said.

The administrator also announced that a special mailing was being made to the membership as a follow-up to the announcement and JOURNAL advertising campaign.

The life program is a portion of the group offerings administered by the Yates organization for the association for 17 years. The entire program is monitored and regulated by the Board of Trustees.

DEATHS

BIGGART, JAMES FLIMEN, Hermanville. M.D., Tulane University School of Medicine, New Orleans, La., 1921; interned State Charity Hospital, Jackson, Miss., summers of 1920, 1921, and 1922; died June 27, 1969, aged 72.

GILBERT, EDWARD LEE, DeKalb. M.D., University of Tennessee College of Medicine, Memphis, 1932; interned City Memorial Hospital, Winston-Salem, N. C., one year; surgery residency, same, July 1, 1933-June 30, 1935; died July 11, 1969, aged 64.

OATES, JUNIUS KENNEDY, Laurel. M.D., Emory University School of Medicine, Atlanta, Ga., 1916; interned Battle Creek, Iowa, one year; postgraduate work, Columbia University, 1938; Emeritus member of MSMA; died July 22, 1969, aged 79.

Better Care Sought For Highway Victims

Improved in-hospital emergency treatment of highway crash victims is the aim of a new educational program to be launched by the American College of Surgeons with financial assistance from the Insurance Institute for Highway Safety.

Dr. William Haddon, Jr., Institute president, announced today that a $15,000 grant had been made to enable the College's Committee on Trauma to undertake the program. The College is matching this amount and also will seek additional funding to expand the program.

Beginning with three eight-week educational projects for physicians to be conducted by members of the College of Surgeons in several parts of the country in rural areas, the program will be expanded nationwide. A majority of deaths from highway injuries result from crashes occurring far from urban medical centers.

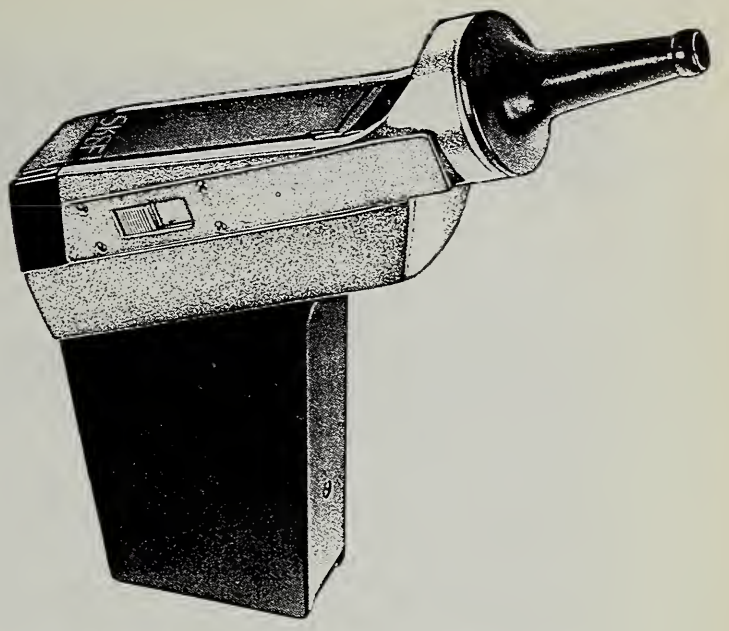
"As physicians and surgeons know, emergency medical care needs, whether on-site or in the hospital, have too long been neglected by the highway safety movement," said Dr. Haddon. "It is gratifying that the College of Surgeons is taking this step to improve the treatment of the injured."

In accepting the Institute grant, Dr. John Paul North, director of the College, said: "The Committee is conducting nationwide educational activities to improve the immediate care and transportation of the injured before they reach hospitals. The College now wants to broaden its trauma program by including emphasis on the closely related in-hospital emergency treatment of the injured.

"At this time there is no organized, comprehensive program of continuing medical education for physicians in emergency life-saving measures for critically injured highway crash victims. Particularly no program exists to provide such education for physicians in their home communities and in the environment of the hospitals in which they practice."

The new program will be under the staff direction of Dr. Oscar P. Hampton, assistant director of the College for trauma activities.

"Comprehensive curricula will be developed for a series of weekly or twice-a-week educational sessions," Dr. Hampton said. "On-site instructional courses will be given by teams of surgeons from the College's Committee on Trauma, or from its state and provincial committees on trauma, to physician-students from the surrounding areas. Visual and printed educational aids will supplement the instruction."



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UMC Announces Faculty Changes

Dr. Stewart Agras, professor of psychiatry at the University of Vermont College of Medicine, will come to the University of Mississippi Medical Center in September as professor of psychiatry and department chairman.

Dr. Agras, 40, is British by birth. He has his M.B. and B.S. degrees from London University and trained at Bedford Hospital, Beds, England and Montreal General Hospital, Montreal, Canada. He has a diploma in psychiatry from McGill University and certification in psychiatry from the Royal College of Physicians of Canada.

Dr. Agras' particular fields of interest are phobia and the recent application of principles of learning.

He is on the editorial board of the *Journal of Applied Behavior Analysis,* has been a consultant to the Vermont State Hospital, and, in 1965, chaired the State Mental Health Planning Study manpower committee. His medical school assignments have included the curriculum, admissions, student affairs, tutorial program, human experimentation, and clinical research center committees.

He is a member of the American and Canadian Psychiatric Associations, the New York Academy of Sciences, American Association for the Advancement of Science, and the Association for Advancement of Behavioral Therapies.

Dr. James Suess, associate professor of psychiatry, who has acted as department chairman for a year, moved up to full professor in July.

A round dozen other new faculty will arrive at the Medical Center by the time classes resume in September. Seven at the assistant professor level are Dr. George Huggins, obstetrics-gynecology, a Missouri graduate; Dr. T. Walter Treadwell, medicine, who got his M.D. at Vanderbilt and took his internship and residency at the Jackson institution; Dr. Frances Morrison, medicine, UMC graduate who took his specialty training at the University of Pennsylvania; Dr. Jeanette Pullen, pediatrics, a Tulane graduate; Dr. Asa Klein, Dr. Ann Wilkes, and Dr. Peggy Coleman, all pharmacology.

New instructors include psychologist Dr. David Barlow who will accompany Dr. Agras from Vermont; Dr. Richard Bennett, medicine; Dr. June Blount, radiology; Dr. Kiroyuki Takagi, surgery (research); radiation physicist Jerry Morris, radiology, and Dr. David Davis, surgery.

Dr. Robert E. Blount, assistant dean, is also University Medical Center assistant director, since July 1 when both Dr. James Suess, psychiatry, and Dr. Tetsuzo Akutsu, surgery, were elevated to full professor.

Dr. Allen Ashburn was promoted to associate professor of anatomy and Dr. Benjamin Byers to associate professor of microbiology. Promotions from instructor to assistant professor went to Dr. Allen Cowley, physiology-biophysics; Dr. Richard Hutchinson and Dr. T. D. Lampton, medicine.

Employ Handicapped Week Set for Oct.

National Employ the Physically Handicapped Week has been set for Oct. 5-11, 1969, by the President's Committee on Employment of the Handicapped.

John R. Callaham, chairman, Business Publications Committee of the President's Committee. has urged all employers to give the disabled men and women a chance to prove their ability.

"In the right jobs," he said, "handicapped workers perform just as well as other workers. Not only that, they often have better-than-average punctuality, attendance and safety records."

President Nixon has said, "I have personally observed the mutual benefits that derive from hiring the handicapped—the physically impaired, the mentally retarded, the mentally restored—and I want this 'good business' to continue and prosper."

"We have acted as judge and jury for the retarded person and often condemned him to the life of a basketweaver in a non-weaving society. . . . There is little use in teaching a retarded youth work habits if misguided people refuse even to consider that he has the potential to work," comments Richard Cardinal Cushing of Boston.

Thomas J. Watson, Jr., chairman of the Board. IBM Corp., adds, "The handicapped worker has not only shown himself to be a good and competent employee; he frequently brings something extra in the way of motivation. He tries harder because he wants to show what he can do. As a result, employment of the handicapped is no longer regarded as an act of compassion; it is a matter of good business judgment. . . ."

Book Reviews

Exploitable Molecular Mechanisms and Neoplasia. A Collection of Papers Presented by the Twenty-Second Annual Symposium on Fundamental Cancer Research, 1968. Published for the University of Texas M. D. Anderson Hospital and Tumor Institute at Houston, Texas. 610 pages with illustrations. Baltimore: The Williams and Wilkins Company, 1969. $17.00.

There must be only a relatively small handful of researchers working to unravel the knots in our knowledge of bio-molecular chemistry, immunology, and heredity. The casual observer, who has difficulty in even understanding the language emanating from these laboratories, can only stand in awe before a discussion of such subjects as Replication of Viral RNA, genetic transcription and translation, DNA Replication in Mammalian Chromosomes, Control of Biosynthetic Pathways by Regulatory Enzymes, and Mechanisms of Carcinogenesis in Relation to Studies on Minimal Deviation Hepatoma.

Such is the substance of the Twenty-Second Annual Symposium on Fundamental Cancer Research held in March, 1968, in Houston, Texas. This collection of papers presented at this conference is, technically, an excellent publication, with good editorial and typographic organization, good reproduction of charts and figures, and apparently few, if any, errors. Having many authors, the subject matter is discontinuous, yet obviously inter-related by virtue of the common interest in searching for the causes of, and rational approaches to control of, cancer. Such a multidisciplinary approach to the subject provides a comprehensive review of many basic cellular mechanisms, which is undoubtedly of interest to students in this field of research, but of very little practical interest to clinical oncologists, much less to physicians in general, except to assure them of the diligent efforts being applied to the search for effective cancer control.

For instance, leukemia and other forms of cancer have been treated experimentally with L-asparaginase to deprive tumor cells of asparagine which is essential to their growth. Handschumacher, in studying this metabolic system, opens up the interesting possibility of blocking asparagine uptake by using metabolic analogs of asparagine, combined with large doses of L-asparaginase itself (if purification problems can be overcome). This approach might offer significant hope of achieving a total tumor cell kill and, consequently, a cure.

6-Mercaptopurine and the purine synthesis systems which it affects are discussed in detail by Brockman, who mentions some possibilities of improving therapeutic potential in this area.

The cancer chemotherapist will certainly not find in this compendium a textbook. In fact, except for the two examples mentioned above, hardly any mention is made of the commonly used chemotherapeutic agents. The subject matter is, rather, much more basic and will appeal primarily to the small cadre of researchers previously referred to.

GUY T. GILLESPIE, JR., M.D.

Textbook of Otolaryngology. By David D. DeWeese, M.D., and William H. Saunders, M.D. 440 pages with illustrations. St. Louis: The C. V. Mosby, Co., 1968. $11.50.

One of the best basic textbooks of otolaryngology has now appeared in its third edition. It is designed primarily for the medical student and the general practitioner, but it is also a must for the resident in otolaryngology. The need for a third edition openly proves the success of this work in achieving its goals.

Written in close collaboration by the two well-known authors without indication of who wrote what, the book is divided into 32 chapters. It begins with physical examination, enters the discussion of oral cavity, pharynx, and nasopharynx, and then proceeds to larynx, trachea, and esophagus. Next follow the nose, sinuses, and their lesions. The ear is covered in further 11 chapters. An outstanding feature is the inclusion of important adjacent areas, facial nerve, salivary glands, cysts and tumors of head and neck, as well as

speech disorders, and rehabilitation of hearing loss.

Exceptionally numerous illustrations on almost every page add greatly to the didactic value of this fine book. Many are photographs, others are carefully prepared drawings, some of the best by "Putzi" Saunders, Dr. Saunders' elegant wife. Each chapter is followed by a selected list of references and the index is really useful.

Many of the previous printing errors, inverted illustrations, or other flaws have been corrected, but a number of such errors still persist, particularly in the legends of illustrations, some of which are still upside down, e.g., fig. 18-2 on p. 251.

This indispensible work should be in the library of all physicians who deal with the diseases of ear, nose, and throat, which includes general practitioners, pediatricians, and otolaryngologists.

G. E. Arnold, M.D.

PG Institute Opens in Fall

The Mississippi Postgraduate Institute in the Medical Sciences will register its first "class" of 20 family physicians this fall.

They will be invited to enroll in a pilot program of postgraduate study comprising 440 hours over four years and leading to a certificate of excellence in postgraduate education. A second group of 20 will be enrolled in the fall of 1970.

The program is one of three components in a continuing education concept embracing physicians and allied health professionals in Mississippi. Mississippi Regional Medical Program funds, approved at the national level in July, will support the institute. The University of Mississippi School of Medicine and the Mississippi State Medical Association are co-applicants in the project which drew heavily on the association's 1968 survey of professional education status and needs in Mississippi as summarized in *Profile of Attainment-Measure of Need.*

Dr. William O. Barnett, professor of surgery and chairman of the MSMA Council on Medical Education, is project coordinator. Dr. Barnett is also chairman of the professional education committee at the University Medical Center, continuing education coordinator for the Mississippi Regional Medical Program, and Chairman of the MSMA Council on Education.

Initially, according to Dr. Barnett, the institute concept will be offered only to physicians because they have had access to more continuing education opportunities than other members of the Mississippi health team. A second segment is phased for nurses and a third will constitute the first steps in providing programs for other allied health professionals for whom virtually nothing is now available in this state.

Designed for physicians in general practice and presented with the cooperation of professional and voluntary health organizations, the carefully structured institute concept includes attendance in two weeklong intensive refresher courses at the Medical Center each year, 15 hours per year in approved seminars and circuit courses, and 15 hours per year at medical and professional society scientific sessions.

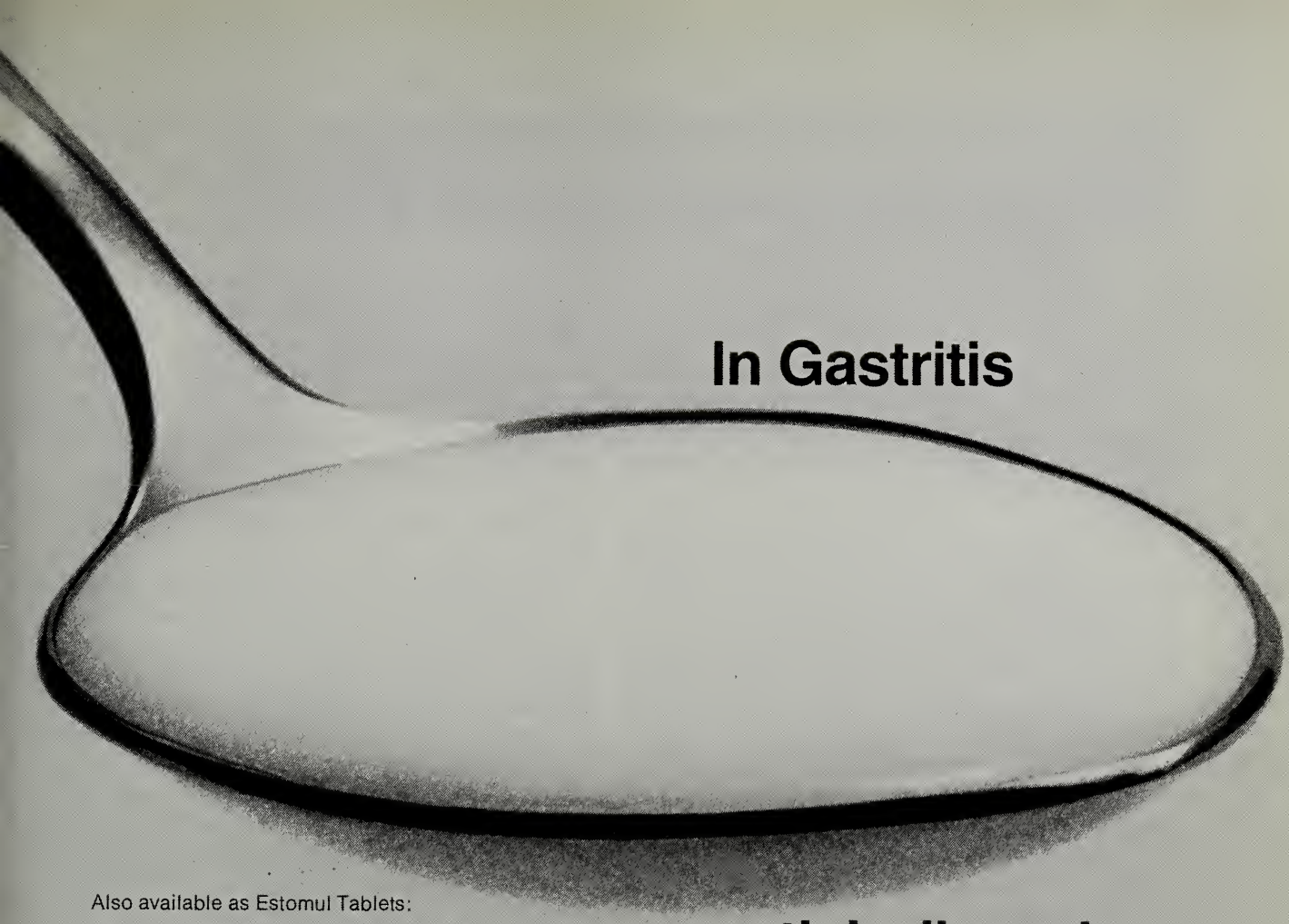
Registrants may attend two of these eight one-week courses to be offered at the Medical Center in the coming academic year. In the fall, programs will be given in pediatrics, October 6-10; electrocardiography, Oct. 13-17; gastrointestinal disorders, Nov. 3-7; and cancer chemotherapy. Spring offerings include cardiology, radiology, renal disease, and stroke.

All courses will be similar in format to the three sessions on stroke which 14 physicians completed in the 1968-1969 academic year. Registration will be limited to four classes of five physicians. Registrants will be reimbursed for travel and receive a modest per diem within University policy and Regional Medical Program guidelines.

Institute participants and all other state physicians may attend any of eight Circuit Courses and select from a schedule of one to three-day seminars opening with Practical Management of Vascular Disease on September 25 and continuing with a variety of topics at monthly intervals throughout the year. Credit may also be earned in Specialist of the Day sessions cooperatively offered by the medical school, Mississippi Regional Medical Program, and local medical staffs.

As set forth in the application for RMP funds, the program's "ultimate goal is to improve medical care for patients in this region by adding to or renewing the knowledge and skills of the health team. More effective utilization of health manpower is also expected to follow." The immediate objective is to use all available resources to put a model for postgraduate education into operation and to test the plan in action.

The medical school and medical association planners also view the pilot program as a first step toward a Mississippi Postgraduate Institute in fact and form as well as in concept with a carefully designed building to house a proven program.



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Addition Progress Sees Foundation Completed

Construction on the addition to the state medical association's Jackson headquarters building is progressing on schedule, according to Dr. Mal S. Riddell, Jr., of Winona, chairman of the Building Committee, and Dr. James L. Royals of Jackson, president.

Foundations and substructures were reported virtually complete after 45 days. This includes deep pilings, underpinning, and steel-reenforced subwalls. More than 300 cubic yards of concrete have been poured in the modular forms in which heavy steel, ranging from perimeter framing of an inch and a half to rods, was set.

The soil pipe component of the plumbing has been roughed in to accommodate installation of a suspended floor at the lower level, according to W. R. Bob Henry, A.I.A., of Jackson, project architect. Electrical conduit below floor has also been set in place.

Drs. Riddell and Royals said that barring adverse weather and other unforeseen difficulties, the construction schedule of 180 days could easily be met. The critical period is the first half or three months when the project is most vulnerable to weather.

August schedules call for erection of structural steel and framing the roof. Walls will be masonry exterior over rigid walls with cavity spaces and thermal insulation. Interior finishes will offer a variety of textures, including prefinished paneling, gypsum board which is painted, and vinyl coverings.

General contractor is Priester Construction Co. of Jackson, a major building firm in the mid-state area.

Dr. Riddell said that the Building Committee is working with the Board of Trustees on necessary furnishings for the addition. The original building, opened in 1956, will be repainted on the interior and other necessary repairs and replacements will be made to bring it up to date with the new addition.

The project was twice approved by the House of Delegates, first in 1967 and again in 1968. At the 1969 annual session, the House approved action of inviting bids for the project. Completion is slated for the end of 1969 with occupancy of the addition by early January of 1970.





Progress continues on the association's building addition project. Left, workman completes steel-setting in substructure on modular forms. Right, giant dragline hoists two tons of concrete per lift as foundations are poured.

Emergency Care Unit Opens to Serve Legislature in Special Medicaid Session

The MSMA Capitol Emergency Medical Care Unit has been "called into special session" to provide medical care during the extraordinary session of the Mississippi legislature, now convened.

The public service project provides almost instant medical care to solons and other Capitol personnel. The program, in its fifth year, employs a full time registered nurse and furnishes the services of a physician during each legislative day.

Dr. James L. Royals of Jackson, association president, was the first "Doctor of the Day" for the 1969 special session. Mrs. Mavis Barlow of Jackson is serving as the professional nurse.

The Council on Legislation supervises the public service project. Dr. C. D. Taylor, Jr., of Pass Christian is council chairman and leader of association activities in the legislative field.

The care unit is staffed by physicians from the state who volunteer a day of service during regular and special sessions of the legislature. Conditions treated during the five previous years have ranged from minor colds to heart episodes.

The unit is maintained in room 401-D of the new Capitol building and is furnished with minimal treatment room equipment. A number of drug manufacturers make notable contributions of drugs to the unit as a public service and the association provides all the other supplies.

The last regular session, 1968, was the longest in the history of the state. There were 132 legisla-



Welcoming the Mississippi State Medical Association's medical service to the legislature on the opening of the special session are House Speaker John R. Junkin, left, and Lt. Gov. Charles L. Sullivan, right. Mrs. Mavis Barlow of Jackson is the full time registered nurse, and Dr. James L. Royals of Jackson, MSMA president, served as first volunteer "Doctor of the Day."

tive days over seven calendar months. The EMCU opened on Jan. 8 and closed on Aug. 9.

During that session, the records show that a Doctor-of-the-Day was actually present during 58 of the 132 legislative days. Jackson physicians were on call during the other 74 days.

The Central Medical Society furnished 21 DOD's and 74 days on call service. Five of the 17 component societies furnished no DOD's; three societies furnished one; two societies, two; two societies, three; and four societies more than three. The North Central District Medical Society, our smallest multi-county group, furnished the most DOD's next to the Central, with the Delta and East Mississippi as close runners-up.

The records show that there were 436 visits to the EMCU during the session. Upper respiratory infection was the most commonly diagnosed condition, and there was daily monitoring of blood pressure. Other conditions seen ranged from headache, contusions, a hematoma from undisclosed trauma, to four heart episodes, two of which were fatal.

On one occasion, a painful toenail was trimmed, fortunately by a certified surgeon, and one record shows that "reassurance" was given a representative by the DOD who is a diplomate in preventive medicine. The day a psychiatrist served, he saw only URI and one nauseated secretary on the staff. There was a mean of 3.3 visits per day.

Visits by patient classification include 31 senator visits, 240 visits by representatives, 10 by pages, 11 visitor visits, 137 from the legislative staff and seven by news media representatives, to yield a total of 436 visits to the care unit.

The Emergency Medical Care Unit has been characterized as a worthwhile experiment for both the physicians and the legislators. Patient visits have increased regularly and the unit has become an accepted and integral part of life at the Capitol.

UMC Midwifery Course Set for September

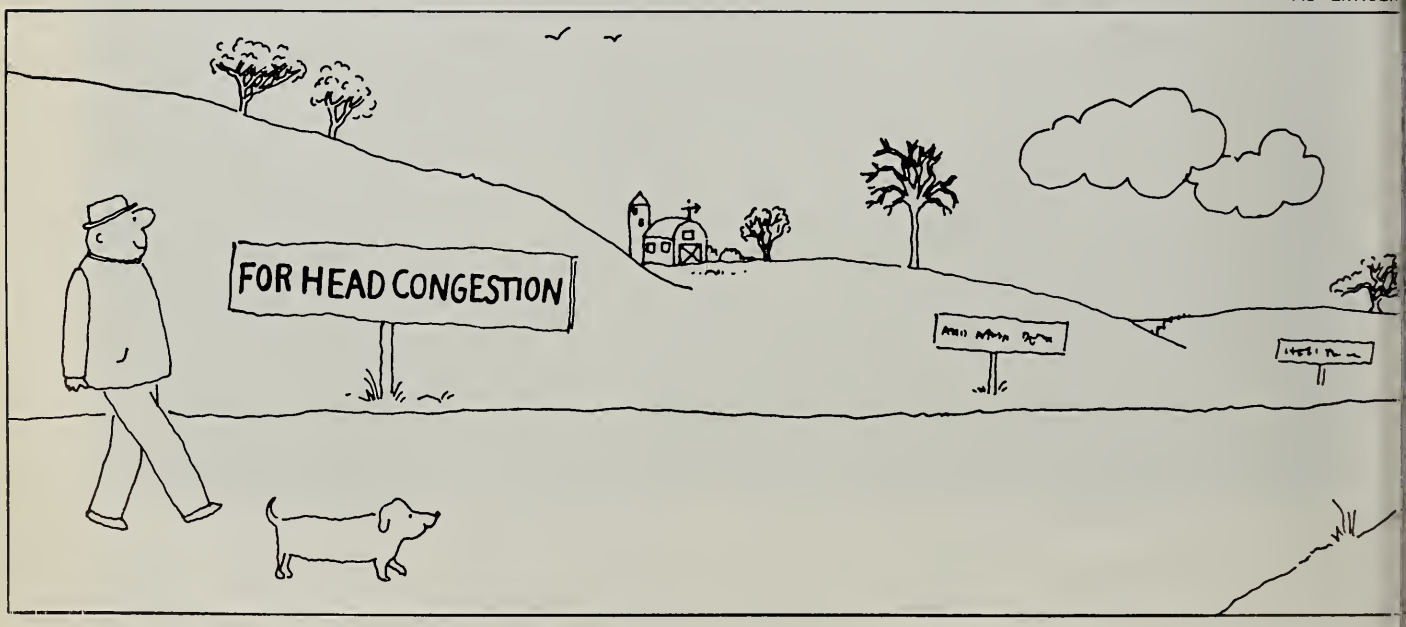
A postbaccalaureate course in nurse-midwifery will be offered at the University of Mississippi Medical Center, Jackson, beginning in September, 1969. Six students will be accepted.

A grant from the Children's Bureau, Department of Health, Education, and Welfare, supports the program which is part of a comprehensive project to improve maternal and infant health in a five-county target population.

The course will cover four academic quarters, including a preceptorship in the project site. Nurse-midwives will be encouraged to work in the area after completion of the course.

The curriculum will conform to the standards of the American College of Nurse-Midwifery. Successful completion will lead to a certificate in nurse-midwifery from the University of Mississippi. Faculty hold joint appointments in the School of Nursing and School of Medicine, Obstetrics-Gynecology Department.

ADVERTISEM



Nurses accepted will be trained to provide prenatal care, manage normal—labor and delivery, and give postpartal care, all with physician consultation.

Qualifications for the course are graduation from a professional school of nursing accredited by the National League of Nursing and a baccalaureate degree with an upper division major in nursing, current licensure as a registered professional nurse in one state of the United States and eligibility for Mississippi licensure.

No tuition fee will be charged. The grant provides a monthly stipend of $250 and $25 a month for each dependent.

Requests for applications or information should be directed to Miss Marie Meglen, Director, Nurse-Midwifery Program, University Medical Center, 2500 North State Street, Jackson, Mississippi 39216.

12th Conference Slated on Physicians and Schools

"Youth and Today's Environment" is the theme of the October 8-11 12th National Conference on Physicians and Schools scheduled at the Pick-Congress Hotel in Chicago. Following the opening by Dr. Gerald D. Dorman, New York, AMA president, participants will gather in several sessions to discuss school health education programs, the "pressing problems of youth," adolescents' skin problems, and drug abuse.

Family-Planning Goes to 3 Counties

A comprehensive family planning project is under way in Hinds, Rankin, and Madison counties, according to Dr. H. B. Cottrell, executive officer, State Board of Health.

Dr. Cottrell said the State Board of Health has received approval and a grant of $66,000 for the project from the Children's Bureau of the Department of Health, Education, and Welfare.

Dr. William E. Riecken, Jr., is project director, coordinating activities with Dr. Eric McVey, health officer for Hinds and Rankin counties, Dr. W. E. Noblin, acting health officer for Madison county, and with Dr. Henry Thiede, chairman of the department of obstetrics and gynecology at the University Medical School in Jackson.

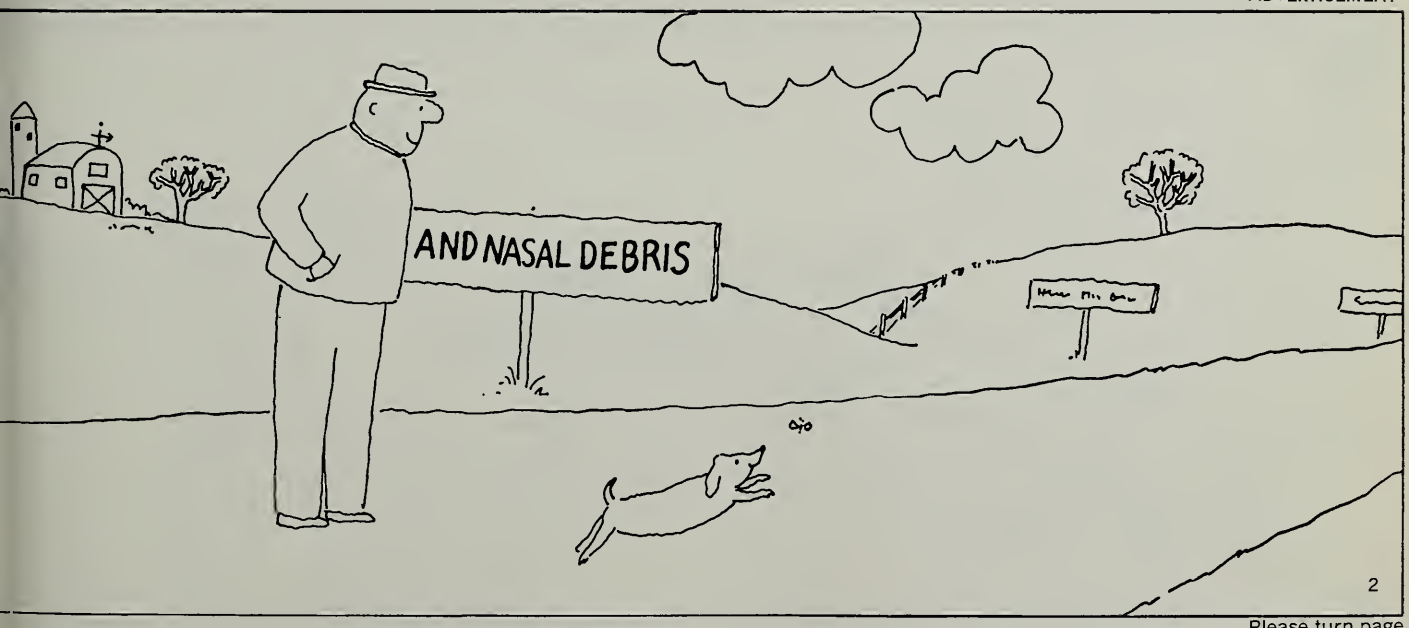
The State Board of Health has offered family planning services through its various county health departments since 1944 as a part of its regular program, but the project now under way is the first of its size and scope.

Dr. Riecken said the purpose of the project is "to provide the means for a family to decide how many children they want—and when they want them."

He said the project can help parents regulate and space childbirths, as desired, recognizing that "Control of fertility and family size is conceded to be a family right."

He said counseling on family planning in the three counties is on a voluntary basis and will be

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provided only to those specifically requesting such service.

The service also includes counseling with childless parents who want to have children. This, too, is on a voluntary basis.

A team consisting of a physician, nurse, and clerk will conduct an average of five clinics a week at county health departments at other locations in the three counties.

"We recognize," Dr. Riecken said, "that more and more parents are becoming aware of the fact that too many childbirths, coming too close together, can be the cause of a number of problems."

"Illness and deaths of mothers and babies are higher in families with many children born close together. Illness and deaths are much higher in premature babies. And mental retardation is more frequent and more severe in large families with babies born close together. Our purpose is to help parents understand these problems."

Birth control procedures will be explained and birth control devices will be provided to those who request them, along with instructions as to proper use.

"We expect the programs," he said, "to strengthen the integrity of the family, reduce the incidence of low-birth-weight deliveries, promote better health for mothers and children, and help reduce maternal and infant deaths."

The project will involve cooperation of the State Board of Health, local health and welfare departments, the University of Mississippi Medical Center, Office of Economic Opportunity, Community Action Programs, and other groups.

Supervising public health nurse for the project is Mrs. Patricia A. Atkinson, a graduate of Baptist Memorial School of Nursing in Memphis.

Southern Internists Plan Scientific Meet

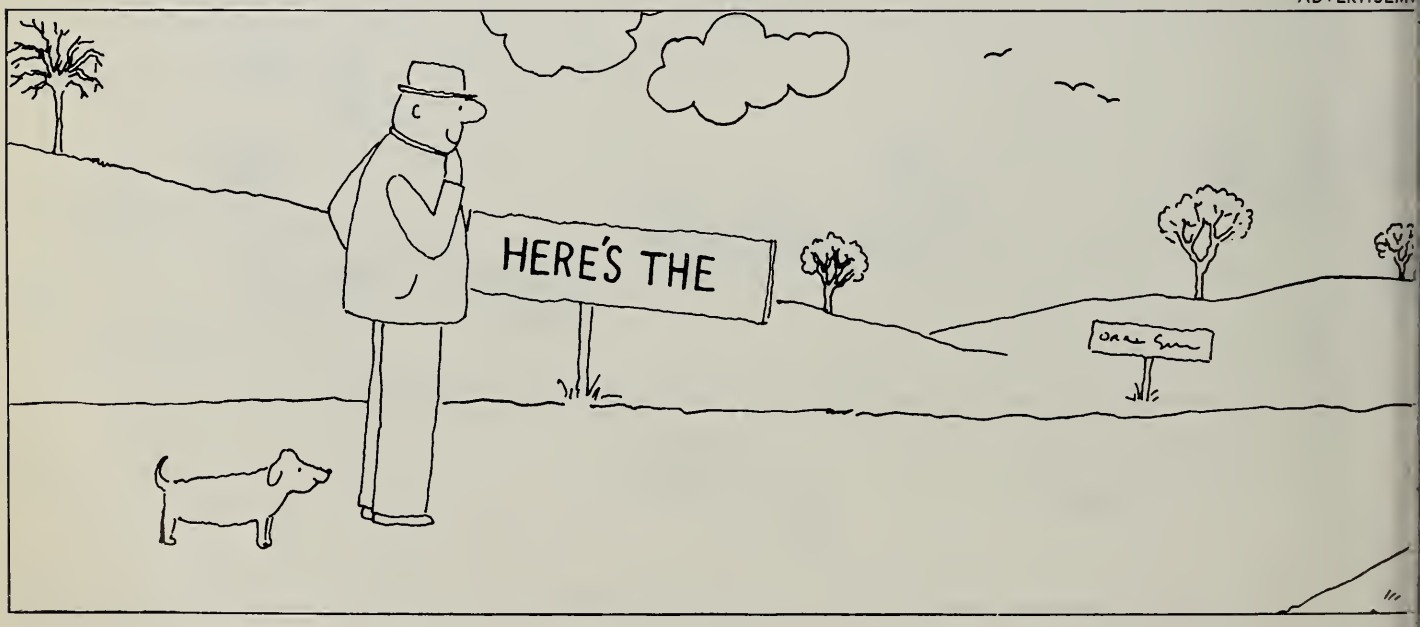
The American College of Physicians (ACP) will sponsor a regional scientific meeting for specialists in internal medicine in the southern states, Sept. 19-21, in Point Clear, Ala.

The meeting will be attended by physicians from Alabama, Florida, Georgia, Louisiana, Mississippi and South Carolina. It is one of 35 regional scientific-educational meetings the ACP will sponsor during the 1969-70 academic year. Held throughout the United States and Canada, the meetings help the College's 15,000 members keep abreast of developments in the basic sciences and clinical medicine.

Special guest at the meeting will be Walter B. Frommeyer, Jr., M.D., Birmingham, Ala., ACP Vice President. Dr. Frommeyer is professor of medicine and distinguished professor at the University of Alabama.

In general charge of the meeting is Howard L. Holley, M.D., Birmingham, Ala., ACP Governor for Alabama and professor in the department of medicine, University of Alabama Medical Center.

ADVERTISEMI



UMC Expands Pediatric Unit

Two new hospital units for pediatric patients opened at the University Medical Center in Jackson in July. Sixteen beds in single rooms are available for medical and surgical pediatric patients on the all-private second floor of the new Children's Hospital and eight pediatric intensive care beds are open on the first floor.

The private pediatric unit is reserved for full-pay patients. All rooms are single units with cots provided for parents who wish to stay with their children. Room reservations are obtained by calling the private admitting office in the usual manner. Patients to be admitted should be asked to come to the University Hospital entrance on the east side of the Medical Center. The private admitting office is just inside this entrance.

Admission to the pediatric intensive care unit is solely on the basis of medical need. To request admission for a patient, please call the hospital switchboard and ask for the admitting resident in pediatrics. State the medical need to the resident who will coordinate the admission with the admitting office.

Patients who will arrive by ambulance or who will need assistance with transportation upon arrival should be instructed to enter through the Emergency Room. A Department of Pediatrics designee will supervise and coordinate all activities in this unit.

In addition to these new facilities and the nursing unit for service patients which opened earlier this year, the Children's Hospital also has a 15-bed pediatric isolation unit located on the first floor. These beds are available for patients with respiratory infections, meningitis, diarrhea, and suspected communicable diseases and for protective isolation. Admission may be arranged in the same manner as in the pediatric intensive care unit.

Florida Hosts Third Hospital Postgrad Meet

"Today's Hospital Problems: An Interdisciplinary Approach" is the theme of the third annual postgraduate conference for chiefs of staff, hospital directors and governing personnel set for Nov. 12-15, 1969 at the Tides Hotel and Bath Club, Redington Beach, Fla.

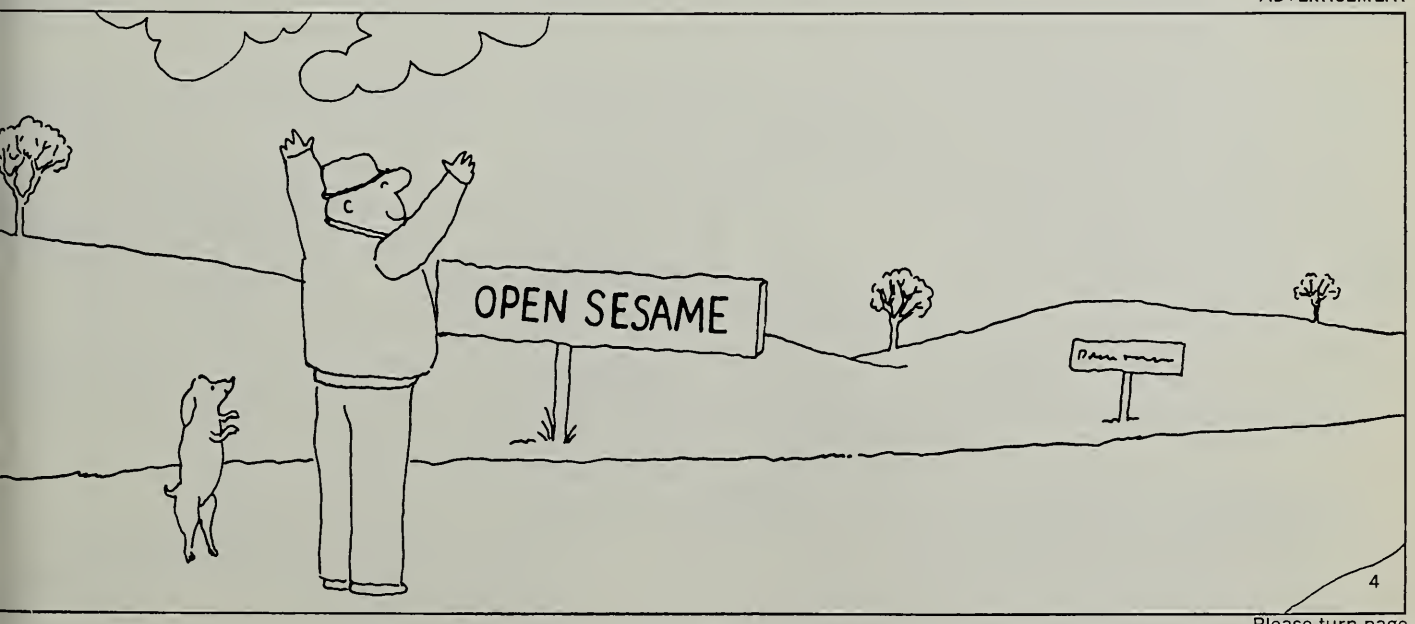
The seminar, carrying 20 hours of AAGP credit, is sponsored by the Mound Park Hospital Foundation and the division of continuing education of the J. Hillis Miller Health Center, The University of Florida, Gainesville.

Guest faculty includes C. Wesley Eisele, M.D., Irvin J. Cohen, M.D., Father Thomas J. Casey, S.J., Malcom Randall, F.A.C.H.A., Paul H. Cashman, Ph.D. and Leonard S. Powers, A.B., J.D., LL.M.

Fee for the course is $100.00 and includes luncheons on Nov. 12, 13, and 14.

Further information can be obtained by writing to: Postgraduate Medical Education, Mound Park Hospital Foundation, 701-6th Street South, St. Petersburg, Florida 33701.

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Tests of Measles Vaccine Scheduled

Pilot clinical trials of a vaccine for German measles are planned this month by The Dow Chemical Company.

Following the pilot tests in Illinois and Ohio, Dow plans major clinical trials this fall.

The company seeks to obtain licensing by the National Institutes of Health (NIH), in time to help block an expected outbreak of German measles in 1970.

Dow is the nation's largest producer of a successful vaccine for common measles, which has dramatically reduced the incidence of that childhood disease. The company's Rx Pharmaceuticals arm in Indianapolis has distributed 30 million doses of Schwarz strain rubeola measles vaccine, developed by Dow research, since its licensing in 1965.

For the German measles trial, Dow will use HPV-77 rubella virus strain developed by scientists of NIH and grown in a tissue culture at Dow laboratories at Zionsville, Ind. The NIH virus strain is also being used by other major vaccine producers in their testing programs.

All research results will be submitted to NIH for evaluation and licensing prior to general use by physicians. The clinical trials will be conducted primarily in children over age one.

German measles, or rubella, hits hardest at children in kindergarten and the early grades of elementary school, reaching a peak in March, April and May.

If the disease is contracted by women in the early months of pregnancy, it can cause abortions or birth defects such as blindness, deafness, heart disease and mental retardation. An epidemic in 1964-65 was followed by more than 50,000 deaths of unborn babies or birth deformities, according to the Department of Health, Education and Welfare.

The disease tends to flare up in six to nine year cycles, leading to forecasts by epidemiologists of a significant upswing in German measles in 1970 or early 1971.

Government and industry scientists seek to halt the course of the disease by eliminating its transmission among children, who are the major source of infection for pregnant women.

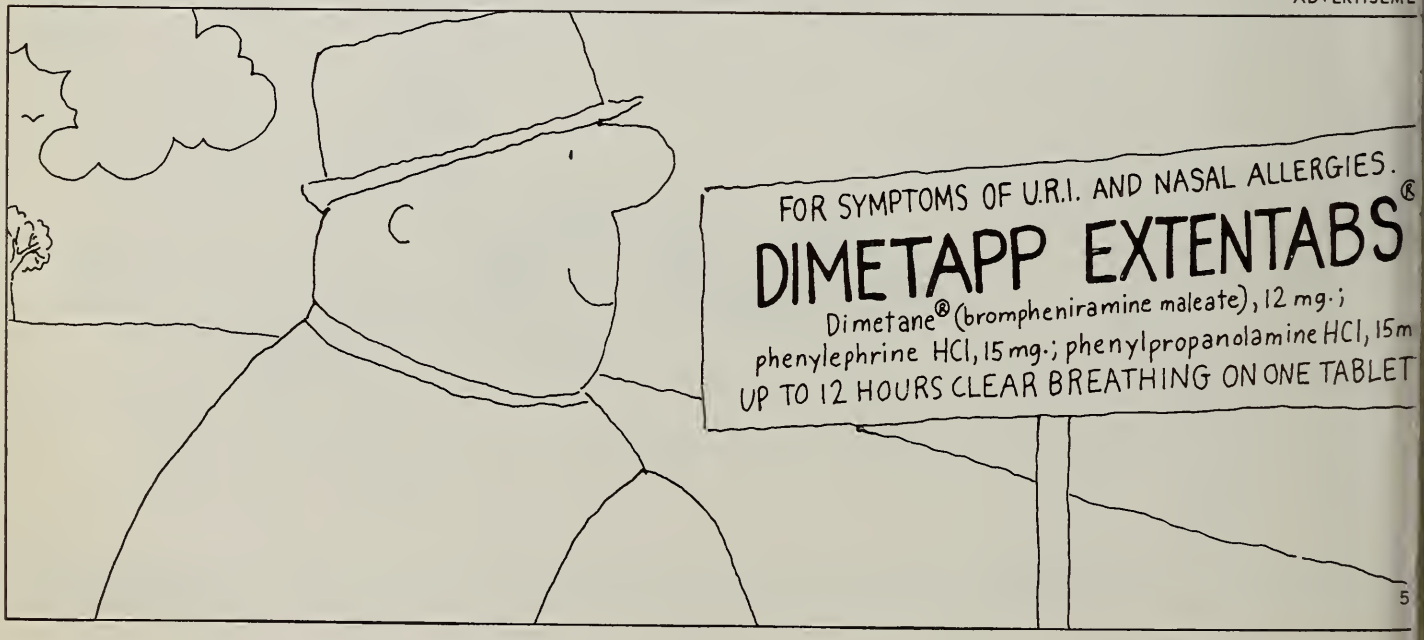
Within the next few years, Dow virologists expect to produce a three-way vaccine that will eradicate three childhood diseases—measles, German measles and mumps.

Medical Center Ups Enrollment to 90

The University of Mississippi School of Medicine freshman class will increase from 85 to 90 students with the class entering in September.

Dr. Robert E. Carter, Medical Center director and medical school dean, announced the enrollment increase after the Board of Trustees, Institutions of Higher Learning, June meeting. He said the five-student increase is in direct response

ADVERTISEME



to the state's investment of more dollars in the medical school.

In seeking its 1968-70 appropriation, the school pledged to expand enrollment if the state could furnish the necessary support.

The 1969-70 enrollment increase marks the second time the entering medical class has expanded since the Medical Center opened in 1955. Dr. L. L. Sulya, chairman of the admissions committee, states that quality and quantity of applicants is more than adequate to permit class increases without any drop in academic standards.

Seventy-five per cent of the school's graduates who have completed training and entered practice are located in the state, records show.

Nuclear Medicine Schedules Meet

The Southeastern chapter of the Society of Nuclear Medicine will hold its tenth annual scientific meeting on Oct. 23-25, 1969, at the Sheraton Nashville Hotel, 920 Broad Street, Nashville, Tenn. 37203. The chapter invites participation of all interested persons.

The program will include panel discussions, contributed scientific papers, and teaching sessions on the application of nuclear medicine. The instructional program will be accredited by the American Academy of General Practice.

For information regarding participation in the program, contact: Richard L. Witcofski, Ph.D., department of radiology, Bowman Gray School of Medicine, Winston-Salem, N. C. 27103.

For other information, including registration, contact: Robert H. Rohrer, Ph.D., department of physics, Emory University, Atlanta, Georgia 30322.

Governor Names Eight M.D.'s to CHP Body

Eight physicians have been named by Gov. John Bell Williams as members of the Advisory Health Planning Council for the Comprehensive Health Planning program in Mississippi.

The body, which has a majority of one consumer as required by federal law, will monitor and in effect govern the program. Dr. Alton B. Cobb of Jackson is director, and the project is an activity of the Governor's office.

Named to the council are Drs. Temple Ainsworth of Jackson, Edley H. Jones of Vicksburg, and William E. Lotterhos of Jackson.

Also appointed were Drs. Verner S. Holmes of McComb, Gilbert R. Mason of Biloxi, Rhea L. Wyatt of Holly Springs, Guy D. Campbell of Jackson, and the state health officer, Dr. Hugh B. Cottrell of Jackson.

The council will have a total of 31 members, the announcement said. Under the Comprehensive Health Planning enactment, a majority of members must be consumers of health care. Gov. Williams named 16 providers, the maximum permitted, among which eight are physicians.

The group will monitor, direct, advise, and assist in the marshaling of the state's health resources under the CHP program.

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6

Med Students Get First-Hand Training

Some medical students are getting a good first-hand look this summer at the services performed for Mississippians by the State Board of Health through its local clinics.

And they report that they are impressed with what they are seeing—and somewhat surprised to discover what a wide range of public health services are performed by the agency.

"I've been surprised at the wide diversification of activities in which the State Board of Health is involved," says Hunter Eubanks, of Starkville.

"It's been quite an eye-opener," says Glen Graves, of Jackson. "I didn't realize how many areas are involved in public health. I'm surprised at its scope."

Both Eubanks and Graves will be seniors next year at the University of Mississippi Medical School in Jackson, and both are assigned to the State Board of Health this summer.

The work they are doing this summer is not an academic requirement, and they get no academic credit for it. But they are paid—through a U. S. Public Health Service grant to Dr. Robert E. Carter, who sought the funds for this purpose. Dr. Carter is director of the University Medical Center and dean of the Medical School.

Noting that this is the second year that the State Board of Health and the University Medical Center have cooperated in the program, Dr. H. B. Cottrell, executive director of the State Board of Health, makes this comment:

"We're glad to have the opportunity to work with Mississippi's future physicians and to provide an opportunity for them to observe public health workers in action in Mississippi."

The students recognize the opportunity, too. Says Eubanks:

"It's a worthwhile experience. It gives us a chance to see things we wouldn't see in a big university center. I'm especially interested in visiting the clinics."

Their itinerary, coordinated by Terry Beck, in the State Board of Health's Chronic Illness Division, gives both students ample opportunity to visit a variety of clinics, including general clinics and clinics for heart, arthritis, family planning, pediatric screening, venereal disease, and examinations for job applicants under an Office of Economic Opportunity manpower program.

These visits will take them, by the time the summer is over, to Belzoni, Brookhaven, Carrollton, Cleveland, Columbus, Fayette, Forest, Greenville, Greenwood, Hattiesburg, Kosciusko, Macon, Meadville, Meridian, Pascagoula, Port Gibson, Quitman, Starkville, Vaiden, Vicksburg, Winona, and to a pediatric clinic at the University Medical Center.

"I've seen many patients at these clinics," says Eubanks, "who don't have their own doctor and who probably wouldn't be able to get any medical help without going through health department clinics. Visits to these clinics have helped me to appreciate what a good job is being done there."

His fellow student, Graves, says he thinks more medical students should have the same kind of opportunity to observe programs and facilities of public health services as exemplified in the county health departments.

"The most significant thing for the medical student," says Graves, "is the opportunity to see general health problems, as opposed to the referral-type cases we see at the medical center.

"At the county health department clinics, we see the every-day problems which have to be handled without the specialized facilities which a large medical center has."

The students are limited in what they can do at these clinics, since they are not doctors. But both say they have had an opportunity to help as well as to observe, while at the clinics.

What they are seeing is State Board of Health personnel engaged in screening patients for signs of glaucoma, diabetes, high blood pressure and other problems which may be aided with early detection.

They are also seeing evaluation of tuberculosis patients, tuberculin skin-testing procedures, and a wide variety of examinations and treatments at the county level.

Carrying out this multiplicity of duties are county health officers, nurses, sanitarians, technicians, aides and clerks—all working as a team in the 82 counties.

Three other medical students are working throughout the summer at the Hinds County Health Department in Jackson. They are William E. May and Terry Brantley, of Jackson, and Donald W. Barham, of Meridian. A sixth student, Edward A. Steward, of Cockrum, in DeSoto county, is working this summer at the Bolivar County Health Department in Cleveland.

CHIP Seeks Health Officers

Public health officers are needed for the recently funded County Health Improvement Program (CHIP), popularly known as the Delta HEW project during its two years of development.

The program, now funded for just under $1 million, is operated by the University Medical Center and directed by Dr. Albert B. Britton, Jr., of Jackson. It is operative in five Delta counties, Holmes, Humphreys, Issaquena, Sharkey, and Washington.

The program will offer expanded public health services, training of nurse-midwives and health aides, and a limited vendor medical program. It is guided by a nine-member committee consisting of representatives of the state medical association, the Mississippi Medical and Surgical Association, the State Board of Health, the University Medical Center, and five consumer representatives.

Dr. Britton said that three physicians are needed in the expanded public health program. Preferred are those with the MPH degree but well-rounded trainees are deemed acceptable without the public health attainment, Dr. Britton said.

The program is based at the University Medical Center which is the grantee for the project.

Community Health Week Set for October 19-25

The seventh annual observance of Community Health Week will be October 19 through 25 in most participating localities, the American Medical Association has announced.

The recurring national theme is "Teaming up for Better Health."

Community Health Week was established by AMA's House of Delegates in 1962 to focus attention on continuing advances in health care and medical science, and the application of these advances in the community. Further, it serves to pinpoint local health problems and needs.

Planning and promotional materials developed by AMA's Communications Division concentrate on two timely themes—recruiting health manpower and emergency medical identification.

This material points out that long-range plans to significantly increase the number of physicians had been instituted in the late 1950's by the AMA, Association of American Medical Colleges, and interested parties at state and local level.

It also explains that physicians, by 1975, are expected to be graduating at a rate of at least 10,000 annually, or 2,000 more than the 1968 rate. In addition, there are at least 200 professional career opportunities in the health field.

Emergency medical identification is important, the AMA emphasizes, because a fifth of the U. S. population has health problems that could cause an emergency or could be made worse by one. These individuals should wear a signal device or tag which has the universal symbol of emergency medical identification and a few words naming the problem.

The universal symbol is a star with the snake-entwined staff of Aesculapius (Greek god of medicine) superimposed. It was developed by AMA.

Community Health Week is sponsored by the medical profession, and programs are coordinated through state or local medical societies.

Dr. Campbell Chosen Med Assistant Sponsor

Guy D. Campbell, M.D., Jackson physician, was recently elected to serve as physician advisor to the Mississippi Association of Medical Assistants. The announcement was made today by Mary Adeline Pace, state president.

Dr. Campbell is coordinator, Mississippi Regional Medical Program, and chief, Pulmonary Disease Section, V.A. Hospital, Jackson. An associate professor of medicine at the University of Mississippi School of Medicine, he previously served on the staffs of Tulane University School of Medicine, New Orleans, and the Mississippi State Sanatorium.

He is a member of the Mississippi State Medical Association and the American Medical Association and has served as president, Mississippi Thoracic Society; president, Mississippi Chapter, American College of Chest Physicians; a member of the board of directors and president, Mississippi Tuberculosis Association; councilor, American Thoracic Society; governor, Mississippi Chapter, American College of Chest Physicians; president, Southern Chapter, American College of Chest Physicians; and is president-elect of the Southern Thoracic Society.

He became a Fellow in the American College of Chest Physicians in 1959 and a Fellow of the American College of Physicians in 1965. He is also a diplomat of the American Board of Internal

Medicine and a diplomat of the Subspecialty Board of Pulmonary Disease.

A native of Lauderdale, Mississippi, Dr. Campbell was educated at the University of Mississippi and Harvard Medical School. He received further training at the Mississippi State Sanatorium and the Veterans Administration Hospital in New Orleans.

Medical Assistants Certified in June

At the end of June, 288 medical assistants were tested for certification in 32 test centers throughout the U. S. The examinees were a record total and until the testing only 282 assistants had been certified.

The essentials for an accredited educational program were developed by the American Association of Medical Assistants with the cooperation of the American Medical Association and the American Association of Junior Colleges.

The annual convention of the AAMA will be held October 15-19 in Honolulu, Hawaii, to which all assistants and other medical office staff personnel are invited.

Pediatricians Announce Program for Child Health Personnel

The American Academy of Pediatrics has taken a major step to improve the delivery of child health care in the United States by initiating a national program to train allied child health personnel including pediatric nurse associates, pediatric office assistants, and pediatric aides.

The Academy hopes that more than 6,000 associates, assistants, and aides will be trained within the next five years, thereby greatly increasing the pediatrician's capability to provide comprehensive pediatric care to larger segments of the public.

To implement this program, the Academy Executive Board, meeting in Evanston, approved the establishment of a Division of Child Health Manpower within the AAP Central Office.

The AAP Executive Board also unanimously endorsed as official Academy policy the position that a physician may delegate to a properly trained individual working under his supervision, the responsibility of providing appropriate portions of health examinations and health care for infants and children.

Specific objectives and responsibilities for the AAP Division of Child Health Manpower are now in the planning stage. However, responsibilities may include development of training guidelines, accreditation of educational institutions training such personnel, and certification of allied child health personnel.

The Academy has recommended development of the following classifications of child health personnel:

Pediatric Nurse Associate: A registered nurse who has completed a diploma nursing program, an associate degree nursing program, or is a graduate of a baccalaureate nursing program. This associate will also have completed a recognized pediatric nurse associate (practitioner) program of about nine months' duration. A pediatric nurse associate's responsibilities may include activities that are directly related to patient care, i.e., obtaining medical and health histories; performing portions of the physical examination; giving information and counsel; and managing health problems. These tasks will be performed under the supervision of a physician.

Pediatric Office Assistant: A pediatric office assistant will, when possible, have completed at least two years of college or its equivalent, or be a graduate licensed visiting or licensed practical nurse. She will work under the supervision of a physician or a nurse associate. Her responsibilities may include activities that aid the physician or nurse associate in patient care; i.e., obtaining medical histories, performing screening procedures, and various administrative, clerical and minor technical functions, or other duties as the physician or nurse associate may direct.

Pediatric Aide: A pediatric aide when possible, will have completed at least high school or its equivalent. A pediatric aide will usually be trained on the job by a pediatrician certified by the American Board of Pediatrics. She will work under the supervision of a physician, pediatric assistant, or pediatric nurse associate.

These classifications are subject to changes. The American Medical Association in cooperation with the medical specialty organizations including the AAP, is presently studying the classifications of allied health personnel to develop standardized terminology.

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CONTENTS

ORIGINAL PAPERS

Therapeutic Considerations in Endometrial Cancer — 451 — RICHARD C. BORONOW, M.D.

Glaucoma Therapy Simplified — 457 — MERRILL M. KNOPF, M.D.

SPECIAL ARTICLES

Venomous Snakebites: Fiction Versus Fact — 462 — HENRY M. PARRISH, M.D., Dr. P.H.

Radiologic Seminar LXXXVIII: Ischial Apophysiolysis — 466 — T. S. MCCAY, M.D.

EDITORIALS

The United States Senate: No Place to Grow Old — 469 — Declining Lifespan

Let's Make Medical Education Number One! — 470 — AMA-ERF Appeal

Injurious Sensationalism Over Medicare Fraud — 471 — News Media Excesses

New Progress in Care of Alcoholism — 474 — Forward Thrust

Straining at a Gnat, Swallowing a Camel — 475 — Medicaid

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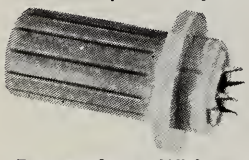
The President Speaking — 468 — The Call Was Answered

Medical Organization — 481 — Press, Government Overplay Medicare Fraud

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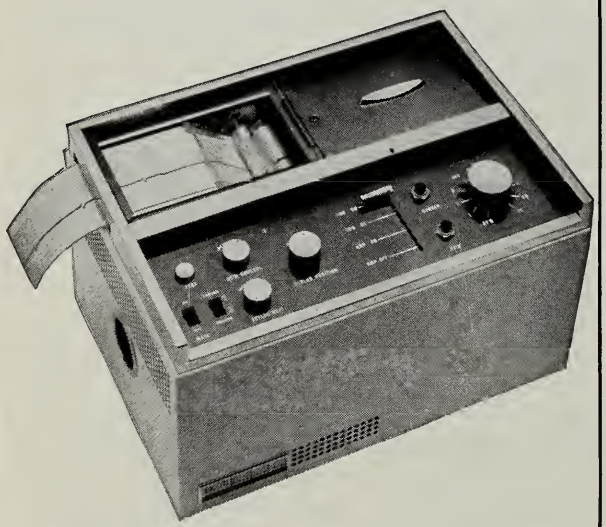


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Dermatology Academy Schedules Meet

The American Academy of Dermatology (AAD) will hold its 28th Annual Meeting Dec. 6-11, 1969 in Bal Harbour, Fla. All scientific sessions and postgraduate courses will be held at the Americana Hotel.

The AAD meeting will include two full days (Sat. and Sun., Dec. 6 and 7) of postgraduate courses in clinical dermatology and cutaneous biology. On Monday through Thursday (Dec. 8-11) research and clinical investigators will give scientific papers on their studies of the causes, diagnoses and treatments of skin diseases.

Special features include an all-day symposium on gross and microscopic dermatology, during which some 100 dermatologists will give short reports on rare and unusual cases; a Residents' Forum for presentation of research papers by dermatologists-in-training, and a series of breakfast and luncheon conferences and seminars on specific problems.

The annual meeting is expected to attract dermatologists from the United States and several other countries. The Academy, which now has over 3,000 members, was founded in 1938 to further the continuing educational interests of dermatologists in clinical practice and to foster the scientific study of skin diseases.

Current officers are: President, Walter C. Lobitz, Jr., M.D., Portland, Ore.; Vice President, Victor H. Witten, M.D., Miami, Fla.; Secretary-Treasurer, Frederick A. J. Kingery, M.D., Portland, Ore.; Assistant Secretary, John M. Shaw, M.D., Tacoma, Wash. and Historian, Samuel J. Zakon, M.D., Chicago, Ill.

Leukemia Conference Slated for Nov.

"Leukemia—Lymphoma" will be the subject of the Fourteenth Annual Clinical Conference sponsored by The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston, November 6-7, 1969.

The two day conference, which will be held at the Shamrock-Hilton, will be co-sponsored by The University of Texas Graduate School of Biomedical Sciences, Division of Continuing Education.

Major sessions will encompass basic concepts, therapeutic and immunological developments,

contributions in radiotherapy, and cytogenetic and histopathological concepts, according to Dr. C. C. Shullenberger, chairman and Dr. Lillian M. Fuller, co-chairman.

The Guy H. Heath and Dan C. Heath Memorial Award will be presented prior to the first session on Thursday, November 6. Established in 1966, the award is conferred annually on a physician or scientist who has made an outstanding contribution to improving care of the cancer patient through clinical application of basic research knowledge.

The Heath Award was established by W. W. Heath, American ambassador to Sweden and former chairman of The University of Texas Board of Regents.

The annual clinical conferences are designed to give the physicians of Texas and North and South America information on the most current diagnostic and therapeutic procedures for investigation and treatment of cancer patients.

Bays Is AHSC International Pres.

Karl D. Bays has been promoted to president, International division, American Hospital Supply Corporation, Harry K. DeWitt, AHSC president announced today. Bays, formerly an operating vice president, will continue to serve as a vice president of the corporation. He succeeds Robert Peters, who will become chairman of U.S.V. Pharmaceutical Corporation.

Bays joined American Hospital Supply division as a sales representative in 1958 and was promoted to region manager for the division in 1962. In 1963 he was named area manager and vice president of American's V. Mueller division. He was promoted to president of the Institutional Industries division in 1958. The same year he was appointed president of American Hospital Supply division and then promoted to vice president of the corporation.

Bays graduated from Eastern Kentucky University in 1955 with a B.S. in Business and English. In 1958 he was awarded an M.B.S. degree by Indiana University.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

October 1969

Dear Doctor:

The U.S. Public Health Service will study medical services and utilization of care during acute phase of killer Hurricane Camille. Teams will interview all physicians who worked in disaster, hospital personnel, and allied professional individuals. Effort is to identify successes and failures for improving disaster care.

> Most unique aspect of study will be census tract survey by preselected households in devastation area. This will mean search and followup on storm victims, whether at Coast or in other areas.

Fall-winter curricula for the Mississippi Postgraduate Institute in the Medical Sciences has been announced to state physicians. A joint project of UMC and MSMA, institute will offer eight 40-hour intensive courses limited to enrollment of 20 physicians this year and 20 in 1970. Program requires 440 hours of credit over four years of which 120 may be electives.

National Governors Conference went on record as supporting a national universal health insurance program. Introduced by N.Y. Gov. Nelson Rockefeller, long a supporter of socialized medicine, resolution carried because of unusual rule of three-fourths majority to amend. Gov. Williams was absent because of hurricane crisis.

National Association of Blue Shield Plans has adopted rigid criteria for utilization and peer review to curb rising care costs. Recent NABSP directors meeting spelled out requirements which include both staff and peer review of physicians' claims. Plans must show that corrective action has been taken against overutilization.

Diabetes Week has been set for Nov. 16-22, and National Diabetes Association has invited full physician participation. Sponsors say that 1.6 million Americans are undiagnosed diabetics. Kits and information have been mailed to local medical societies.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Feds Tighten Rules On Exempt Narcotics

Washington - Calling retail pharmacies "focal points of abuse," the Bureau of Narcotics and Dangerous Drugs has issued new and tougher regulations governing sale of exempt narcotics. Sales may henceforth be made by pharmacists (not store employees) only to persons over age 18. Limits of two ounces of paregoric and eight ounces of other "X" preparations in 48-hour period will obtain. New rules are slated to go into effect Oct. 10.

Hospital Share of Care Dollar Continues Climb

Chicago - Recent studies show that the hospital share of the nation's health care dollar has zoomed to 35.4 cents while there has been a fractional decline of the physician share to 20.1 cents. Drugs, dental, and various other services account for remainder. Insurance coverage of physicians' charges has increased to 36 per cent of charges since 1957 when only 12 per cent were covered.

Bill Will Force Occupational Safety Standards Improvement

Washington - AMA has testified in favor of H.R. 13373, the Occupational Health and Safety Act of 1969. Bill, believed certain to pass, will create national board to promulgate occupational health standards. States with programs at least as strict as national standards may continue to exercise own responsibilities. Otherwise, a state must meet federal standards.

Scrap Cycle Breakdown Is Health Problem

New York - Scrap, junk, and refuse are piling up at a greater rate than the environment can absorb, making a major health problem. Cans, glass, paper, and metallic solids are littering the landscape. At least one suggestion for helping is by Scrap Iron Institute, trade association for industry, which wants tough legislation against auto junkyards. Americans abandon a junk automobile every 30 seconds. Many states have acted against scrap cycle breakdown.

Agencies Differ Over Color TV Radiation

Washington - The Federal Trade Commission has issued warnings about sitting closer than six feet to a color TV set, while the U.S. Public Health Service says that modern color video sets are safe. USPHS has responsibility for radiation monitoring and has taken no action against set manufacturers in over a year.

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Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: Recent studies have indicated that prolonged excessive use of phenacetin may result in nephrotoxicity. Caution should therefore be exercised when administering NORGESIC to patients with renal insufficiency. It should also be used with caution in patients with tachycardia.

Adverse reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, mental confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

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NIH Equipment Symposium Set

Plans have been completed for the 19th Annual Instrument Symposium and Research Equipment Exhibit to be held October 6-9 at the National Institutes of Health. The Institutes, located at Bethesda, Maryland, serve as the center of research activities in the Department of Health, Education, and Welfare.

Some 40 scientists of national and international repute will discuss recent developments in research methods and instrumentation in the symposium. The exhibit will feature the latest products of 73 of the nation's leading manufacturers of research equipment.

Dr. A. J. Sheppard, Food and Drug Administration, Washington, D. C., will serve as chairman of the opening session on gas liquid chromatography amino acid analysis.

Macro-molecular structure and function, biological energy sources, freezing and freeze-drying living cells, data processing techniques for instrumentation, miniaturization in automated analysis, ion exchange chromatographic analysis of biological materials, and photoelectron and auger spectroscopy are among the topics for subsequent sessions.

Dr. Robert Q. Marston, Director of NIH, will welcome participants at the opening meeting in the Jack Masur Auditorium of the Clinical Center at 2:00 p.m. October 6. Other sessions are scheduled for 8:00 p.m. that day, at 2:00 p.m. and 8:00 p.m. on October 7 and 8, and at 2:00 p.m. and 8:30 p.m. on October 9.

The research equipment exhibit will be located in Building 22 at NIH. This year, in a departure from previous practice, most of the research instrumentation will be grouped for exhibition according to function, affording the visitor a ready basis for comparison of equipment items. The exhibit will be open daily from 10:00 a.m. to 5:00 p.m. October 6-9.

Complementing the exhibit, special instrumentation sessions will be held daily in Building 1 at 10:30 a.m. and 1:00 p.m. throughout the meeting. Technically qualified representatives will discuss, demonstrate, and answer questions concerning newly developed instruments and their applicability to laboratory-clinical research.

All persons with an interest in research instrumentation are invited to attend the symposium and exhibit. In 1968, 3,900 visitors were registered from the medical and health-related professions, colleges and universities, and industry.

AMA Publishes New Driver Guide

The AMA *Archives of Ophthalmology* recently featured the new "Visual Factors in Automobile Driving and Provisional Standards," a guide to help physicians determine whether their patients' visual problems may limit their driving proficiency.

Developed by the AMA Committee on Medical Aspects of Automotive Safety, with the assistance from the American Committee on Optics and Visual Physiology, the guide promotes the concept of subdividing drivers as to the degree of responsibility and risk while operating an automobile.

The categories are: Class I—Professional drivers operating large passenger-carrying vehicles; Class II—Commercial taxi drivers and professional drivers operating large non-passenger-carrying vehicles, and Class III—Operators of private vehicles.

The provisional standards cover the determination of central visual acuity, field of vision, color vision, associated ocular pathology, post-operative aphakia and visual function affecting night-time driving.

Physicians are invited to request copies of the guide from the AMA Committee on Medical Aspects of Automotive Safety at the AMA headquarters, 535 North Dearborn Street, Chicago, Ill. 60610.

Dr. Barnard Speaks at AAMA Convention

One of the most heralded speakers scheduled to address the annual convention of the American Association of Medical Assistants in Honolulu Oct. 15-19 is Dr. Christiaan N. Barnard, the famed heart surgeon from the University of Cape Town Medical School and Groote Schuur Hospital.

An equally prominent guest speaker will be Dr. Gerald D. Dorman, New York, president of the AMA.

Another highlight will be the Inaugural Banquet, featuring the installation of officers and the parade of state presidents. Dr. George H. Mills, president of the Hawaii Medical Association, will be master of ceremonies. The outgoing AAMA president, Mrs. Mildred Crawford, CMA, San Antonio, Tex., will be succeeded by Mrs. Ruth Dize, Norfolk, Va.

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Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

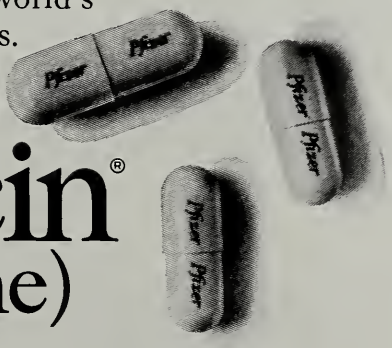
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



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Price of Rh Vaccine Cut Second Time

For the second time in less than a year since the disease preventive was first introduced, the price of a vaccine that prevents Rh hemolytic disease of the newborn has been dramatically reduced.

The new price now in effect, $35.10 a dose, represents a reduction of almost 50 per cent in the price at which it first became generally available, $64.80. Ortho Diagnostics introduced the vaccine, called RhoGAM* Rh_0 (D) Immune Globulin (Human), last June, and reduced the price to $46.60 last October.

The drug is given to Rh negative women within 72 hours after delivering Rh positive babies. It prevents their developing active immunity to the Rh blood factor by suppressing their response to Rh positive cells entering their bloodstreams from their babies.

Because it represented medicine's first use of human antibodies to prevent an immunological reaction, RhoGAM was recognized as posing unique manufacturing problems. But research and experience have permitted even greater efficiencies in its preparation.

In addition, RhoGAM has enjoyed an especially enthusiastic acceptance by the medical profession. The manufacture of more, and larger, batches also makes for greater economies.

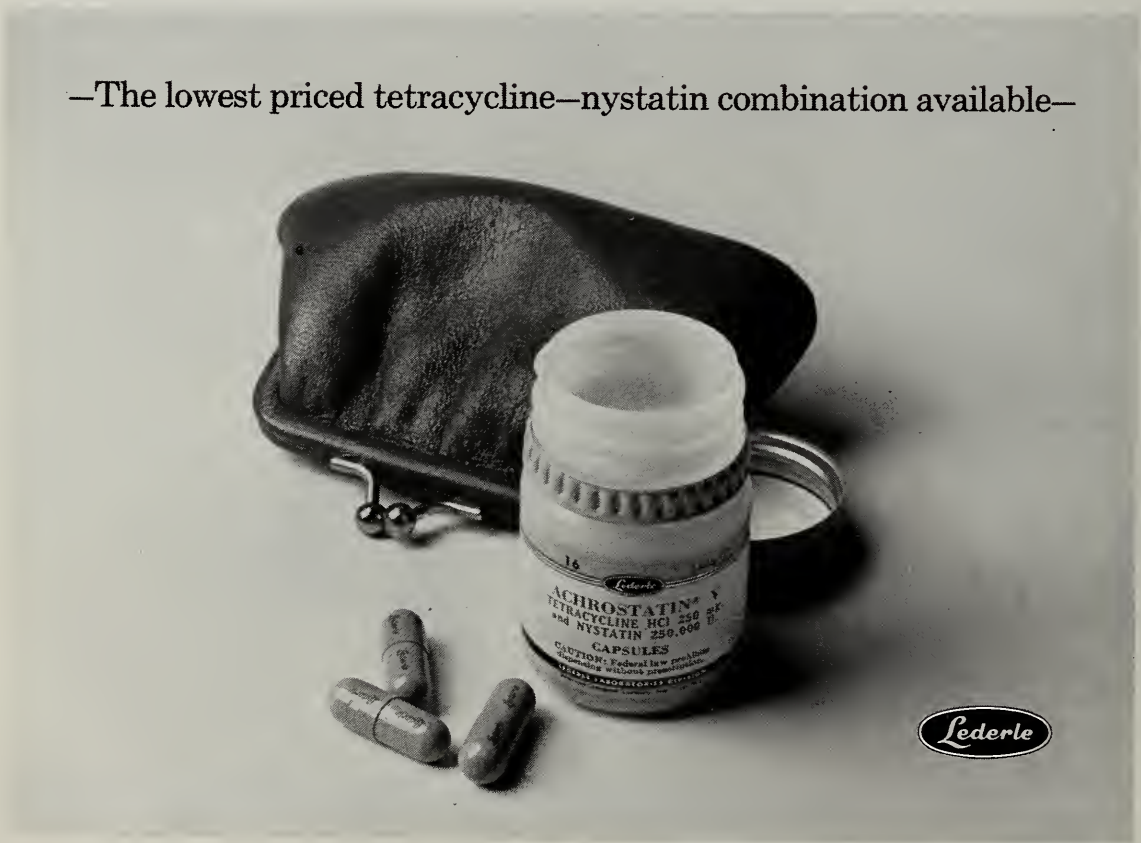
"We are glad to be able to pass these advantages along to you so that you may be able to reduce the final cost to your patients," purchasers were told by Ortho Diagnostics. The company is the country's only commercial manufacturer of the preventive for Rh hemolytic disease of babies.

* Trademark.

Med Assistants Offered Course

The Mississippi Association of Medical Assistants and Mississippi Regional Medical Program are sponsoring an instructional series this year for physician employees.

Presented at the University Medical Center, and open to medical assistants from Hinds, Rankin, Simpson, Madison, Leake, Scott and Yazoo counties, the courses are designed to aid those preparing to become Certified Medical Assistants. The examination for certification is scheduled to be given in Mississippi in June, 1970.



Dr. Joseph E. Varner was instructor for the first course—on medical terminology. Other programs in the series will include presentations on anatomy and physiology, legal aspects of medicine, and medical accounting.

Medical advisors for the series are Dr. Raymond F. Grenfell, Dr. Walter H. Simmons, Dr. Maxwell D. Berman, Dr. E. Leonard Posey, Jr., and Dr. Albert L. Meena.

AHA Explores Health Needs of Poor

Comprehensive health care for all will only be achieved when the providers of health services become totally involved with the people they seek to serve, an editorial in a recent issue of *Hospitals,* Journal of the American Hospital Association, declares.

The AHA editorial points out that the nation's hospitals are being challenged by poor people to use their resources and ability to respond both to health needs and to other social needs.

The entire issue of *Hospitals* is devoted to the delivery of health care services to the poor. Articles explore the need for hospital involvement in delivering those services, and discuss ways in which hospitals can take a leading role in producing the best possible system of comprehensive health care.

According to the editorial, "massive attacks on the nation's health problems" through programs such as Medicare, Medicaid and Regional Medical Programs have "helped those least who need help most."

"White middle-class society still hasn't completed its lesson on social equality of different ethnic groups," the editorial says, "although the providers of governmental service are beginning to realize that the only way to govern peacefully in a democratic society is to ensure involvement of all the groups governed."

The editorial adds: "The lesson to providers of health care is the same—involvement. Only by involvement of and with all recipients of care and all who need care can we actually accomplish comprehensive care. And adequate involvement cannot be achieved by any system, health or otherwise, that fails to see its relationship to the totality of its community—the spiritual, financial and social elements as well as the health elements."

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Med Writers Held Annual Convention

The American Medical Writers Association (AMWA), an international society of writers and editors in medicine and the research sciences, held its 29th Annual Convention Sept. 18-20 in Philadelphia, Pa. at the Sheraton Hotel.

Harold Laufman, M.D., Ph.D., New York, N. Y., AMWA President, said the meeting consisted of workshops in practical problems of medical communications, panel discussions on trends and developments and major addresses by prominent authorities in medical and scientific communications. Dr. Laufman is Director of the Institute for Surgical Studies at the Montefiore Hospital and Medical Center.

A highlight of the meeting was a demonstration of the television equipment and system used during the recent Apollo 11 moon voyage. This same system is being used to take movies of the inside of the stomach as an aid in the diagnosis of stomach ailments. Peter Goldmark, Ph.D., Stamford, Conn., President of the Columbia Broadcasting System Laboratories, which developed the system, demonstrated the equipment and gave a luncheon address on Friday, Sept. 19, on "Deadline For Survival."

The annual convention was planned by a National Program Committee headed by N. Henry Moss, M.D. as chairman. Dr. Moss is Associate Clinical Professor of Surgery at the Albert Einstein Medical Center and the Temple University Health Science Center.

Medicare Announces Policy Changes

The Social Security Administration has announced that routine nursing home care is not covered under the Medicare program. No Medicare payment can be made for less than skilled nursing care in an Extended Care Facility.

Medically necessary skilled nursing care in an Extended Care Facility is covered and Medicare payments can be made if: the patient was a hospital inpatient for at least three consecutive days; the patient was transferred to an Extended Care Facility within 14 days after hospital discharge; treatment required is an "extension" of the hospital care; the condition must require continuous skilled nursing care; or a physician must certify that these above requirements are met.

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Riker was first to formulate medication in a non-irritating, non-alcoholic vehicle.

Riker pioneered pre-grinding of the medication to 1-5 micron size, assuring maximum distribution to the distal bronchioles for greater topical effectiveness with less systemic action. (Oddly, even today not all competitors have adopted these two advances.)

Add to these advantages a quality control system involving 168 physical measurements and chemical tests, plus not one but two test firings on every single unit leaving the plant, and you can readily see why there is no more dependable relief for bronchospasm than your prescription for Duo-Medihaler or Medihaler-Iso.

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SUMMARY OF PRESCRIBING INFORMATION

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Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Northridge, Calif. 91324

Squibb Offers Generation Film

A unique film that explores one of the most important subjects concerning society today was premiered at the 118th Convention of the American Medical Association in New York City, and is now available for local showings.

Entitled "The New Generation," it was produced by E. R. Squibb & Sons, Inc. The 28-minute, 16mm, color feature is the story of our youth today—their ideas, ideals, problems, emotions and philosophy—as seen in the lives of a young American couple. It is a timely story and one that needs to be told for it offers a more realistic view of a generation that is too quickly identified with the demonstrations that have been making current headlines.

What is the vast majority of the new generation really like? They are positive, upbeat, committed and involved. They are young people like Madeline and Laird, a recently married couple, who were selected to tell the story of their generation in this film.

Both have strong feelings about society and its needed changes. They are out to win a world to their liking through constructive action rather than through riots or violent demonstrations. They will achieve their goals simply by being what they are—for they represent "The New Generation"—the leaders of tomorrow.

Flash scene intercutting is used throughout the film. Scenes of Vietnam, urban unrest, and campus protests pop into their consciousness at unlikely times and places to show how these happenings are ever on the minds of the new generation.

In real life, Laird is a senior in college. Madeline works as a part-time model to help put him through school. In her spare time, she works with retarded children in a local hospital. They have a sense of humor and a sense of fun. And it's reflected in everything they do.

A team of movie-makers lived with Madeline and Laird for several weeks filming them in their home and following them through their day-to-day involvements. Their activities, reactions, aspirations and dreams were captured on film.

The film was written and directed by Harold Flender whose "Painting in a Low Voice" won first prize in the documentary category at the Venice Film Festival. He is also the author of "Paris Blues" and "Rescue in Denmark." The producer of the film is Robert Goldman whose work has been concentrated in all areas of education, health and social welfare.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1969, Vol. X, No. 10

ORIGINAL PAPERS

Therapeutic Considerations In Endometrial Cancer

RICHARD C. BORONOW, M.D.
Jackson, Mississippi

Although adenocarcinoma of the endometrium is generally successfully treated with relatively unsophisticated techniques, there is major controversy over the best management. The author discusses anatomical, biological and clinical data and concentrates on the importance of pre-treatment diagnostic steps and clinical staging. Surgical and radiotherapeutic techniques are reviewed, and a plan of therapy is presented.

ADENOCARCINOMA of the endometrium is the second most common gynecologic cancer. Generally speaking, it is relatively successfully treated, with relatively unsophisticated techniques. Yet there is controversy over the "best" management. Before examining the controversy regarding therapy, it should be considered why this cancer is fairly successfully managed. Essentially, it is because the diagnosis is usually made early.

Sixty-five to 75 per cent of these women are postmenopausal. They have a new growth in the endometrium which causes them to spot and then bleed. It is not physiologic to bleed after the menopause. Postmenopausal bleeding means cancer until this diagnosis has been excluded by thorough pelvic examination, D & C and appropriate biopsies.

As more physicians accept these statements as axiomatic and as more patients generally recognize that postmenopausal bleeding is clearly abnormal, this diagnosis will be made with less and less delay.

A small number of women develop adenocarcinoma during their menstrual years, but most who do so are in their late 40s and early 50s when ovarian function and estrogen production wane, and periods tend to be less heavy and less frequent. Changes away from this pattern must be viewed with suspicion.

Table 1 summarizes some of the patient and physician pitfalls in the diagnosis of endometrial cancer. One of the most important areas is the perpetuation of the old folklore that any deviation from normal menses in the climacteric years or even after the menopause may be "normal" and are simply reflections of the "change of life." Failure to be concerned by abnormal uterine bleeding at this time of life by the patient or by her physician may lead to a delay in obtaining histologic proof.

From the Gynecologic Tumor Service, Department of Obstetrics and Gynecology, University of Mississippi School of Medicine.

A Pap smear may be obtained which not infrequently is reported as normal. This provides a false sense of security. The Pap smear is superb for detecting cervix cancer, but with endometrial carcinoma that does not involve the cervix, a Pap smear scrape of the cervix will suggest the diagnosis in only about 50 per cent of cases. An additional slide of the vaginal pool will improve the accuracy slightly. Histologic sections are essential to make the diagnosis, and whenever the diagnosis is suspected, a D & C is mandatory. Given postmenopausal bleeding or abnormal climacteric bleeding a negative Pap smear is no reason for conservatism. On the other hand, if the Pap smear is suspicious or positive, multiple cervical biopsies or a shallow cone biopsy should be performed with the fractional D & C.

CLINICAL OBSERVATIONS

With the diagnosis established, a plan of treatment must be designed. Clearly, controversy exists as to the so-called "best" methods of treatment. Not too long ago in a British review[1] of this subject the statement was made that "it appears that in the best hands there is little to choose between the results obtained from hysterectomy with removal of the adnexa, hysterectomy plus pre- or postoperative radiotherapy, vaginal hysterectomy, and irradiation alone. By each of these treatments, the experts appear to be able to produce a three out of four chance of five-year apparent cure in the most favorable type of case." Certainly in the favorable cases, a 75 per cent chance of cure is obtained. But with the statement, "favorable type of case," is seen both the necessity and the obligation upon the physician for determining a clear pre-treatment understanding of the type of case with which he is dealing. Endometrial adenocarcinoma does present with certain variations in histologic configuration; and probably more importantly, it presents distinctly different anatomical distributions which permit us to clinically stage its extent.

TABLE 1

DIAGNOSTIC PITFALLS

"Change of life" bleeding
Delayed D & C
Reliance on Pap smear

TABLE 2

OLD ENDOMETRIAL CANCER STAGING*

Stage 0
Cases which the pathologist considers most likely to be of carcinomatous nature though it is impossible to arrive at a definite microscopic diagnosis.
Stage I
The growth is confined to the uterus.
Group 1. Operation advisable.
Group 2. Bad operative risks.
Stage II
The growth has spread outside the uterus.

* (International Federation of Gynecology and Obstetrics Staging prior to 1961.)

Most clinicians are familiar with Table 2. This was the accepted International Staging up until 1961. It recognized only two stages: in the first the disease is confined to the uterus; in the second, the disease is spread beyond the uterus. Enough cases have been thoroughly evaluated so that now several important additional differences are recognized. First, when the disease has spread beyond the uterus, even if it is clinically confined to the pelvis, the outlook is grave. Second, if the disease is confined to the body of the uterus the results are quite good—about a 75 per cent five-year salvage. However, if the disease is still within the uterus but has extended to the cervix, the results are much less favorable—a 20-40 per cent five-year salvage. Why this variation within the "old" Stage I? The answer may be found by looking at the lymphatic drainage of the uterus and by borrowing a lesson from the proper treatment of carcinoma of the cervix.

LYMPHATIC DRAINAGE

The lymphatic drainage of the body of the uterus (Figure 1) is primarily along the course of the ovarian vessels (half of the dual blood supply of the uterus). Lymphatic channels are most evident in the deeper myometrial and sub-serosal areas, with the larger vessels. Lymphatic drainage is by way of these channels which exit from the pelvis via the infundibulopelvic ligament (Figure 1-I). Therefore, the most likely lymph nodes involved with metastatic cancer are the aortic, caval, lumbar and high common iliacs. This is not common in early disease and is more likely to occur with extensive myometrial infiltration.

The lymphatic drainage of the cervix (Figure 1-II) and to some extent also the lowest perimeter of endometrium is the well-recognized para-

cervical drainage which follows the uterine veins through their endopelvic support (the cardinal, or Mackinrodt, or transverse cervical ligaments; as well as the deep uterosacrals). This lymphatic network is evident relatively more superficial in the cervix. Thus a given cell mass of cancer in the cervix will more quickly reach lymphatic efferent drainage than a comparable cell mass of cancer arising in the endometrium.

CERVICAL INVOLVEMENT

We now recognize that a simple total hysterectomy is inadequate for invasive cervical cancer; such a limited operation cuts across the paracervical lymphatic channels. Local recurrence is usually predictable. A similarly poor behavior can be expected in those endometrial cancer cases with cervical extension that are treated by a simple total hysterectomy. So it becomes evident that determining the presence of cervical involvement is essential. The new International Classification of 1961 separated these two variants into Stage I and Stage II, and separated spread outside the uterus into Stage III and Stage IV (Table 3).

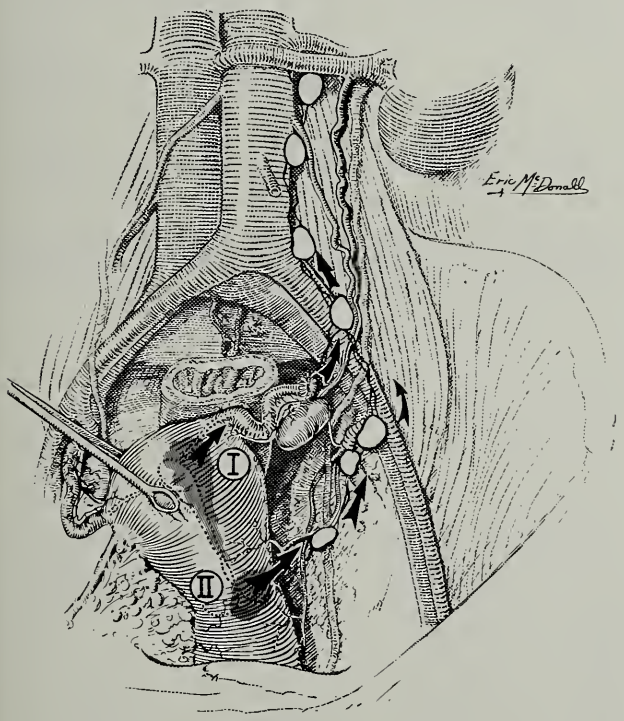


Figure 1. Dual lymphatics of the uterus. Stage I endometrial cancer (I) drains via the infundibulopelvic ligament, primarily to nodes of the pelvic brim and retroperitoneal abdominal nodes. Stage II endometrial cancer is extension to involve both corpus and cervix (II) and drains primarily via the paracervical lymphatics to the pelvic nodes.

TABLE 3

CURRENT INTERNATIONAL STAGING*

Stage 0
Histological findings suspicious of malignancy but not proven.
Stage I
The carcinoma is confined to the corpus.
Stage II
The carcinoma has involved the corpus and the cervix.
State III
The carcinoma has extended outside the uterus but not outside the pelvis.
Stage IV
The carcinoma has extended outside the true pelvis or has obviously involved the mucosa of the bladder or rectum.

* (International Federation of Gynecology and Obstetrics.)

Within the last decade it has been repeatedly demonstrated that the anaplastic or poorly differentiated lesions seem biologically more virulent than the well-differentiated tumors. Brunschwig and Boronow[2] found that with the well-differentiated tumor (which is more likely to be found confined to the endometrial cavity itself, or with only superficial myometrial invasion) the 5-year cure rate is in the order of 80 to 90 per cent of cases. With the moderately differentiated lesion, (usually showing superficial myometrial invasion, sometimes deep myometrial invasion) the curability falls in the 60 to 80 per cent range. Finally with the anaplastic or poorly differentiated tumors (much more frequently with deep myometrial infiltration, sometimes to, or through the serosa; and often with vascular permeation) the cure rate drops to the range of 30 to 50 per cent. Table 4 summarizes the essentials of the pre-treatment assessment thus far discussed. All of this must be considered, before one proceeds with hysterectomy or other treatment.

TREATMENT PLAN

Reference has been made to various modalities and methods of treatment. The areas of principal debate will be considered within the frame of reference of specific clinical stage. It is appropriate to consider the rationale for the use of radiation therapy in the treatment of endometrial adenocarcinoma.

We recognize that radiation therapy alone can cure a certain number of patients with adenocarcinoma of the endometrium, so it must be biologically effective. Therefore, it seems rational to employ radiation therapy in conjunction with sur-

gery. Whether in any individual case, or series, this combined therapy will be statistically superior is not clearly established (infra vide).

It would appear that the available clinical and histologic information that is gathered with the pretreatment assessment can provide certain guidelines with which to evolve a treatment plan in each case.

TABLE 4

PRE-TREATMENT ASSESSMENT

1. Fractional D & C and multiple cervical biopsies
2. Pelvic exam under anesthesia and clinical staging
3. Knowledge of histologic differentiation
4. Other physical findings (abdomen, nodes, lungs, legs, etc.)
5. Chest X-ray
6. IVP
7. Cystoscopy, proctoscopy as indicated

Extrapelvic Stage IV. Clearly this is a palliative situation. The high potency synthetic progestins are useful. Temporary objective regression on the order of 33 per cent may be expected.

Pelvic Stage IV. Massive pelvic disease is an indication for combined external beam therapy and radium. An occasional case will be suitable for pelvic exenteration.

Stage III. Extensive lesions in the pelvis may be effectively palliated. Very early Stage III cases (those with minimal parametrial or vaginal extension) will sometimes be cured by combined therapy.

Stages III and IV. These cases represent less than 10 per cent of the cases of endometrial cancers.

Stage II. These cases account for 10 to 15 per cent of endometrial cancers. This means cervix spread. (The old, so-called, corpus et collum, cases.) Of course, some cases with cervix spread —because of extension into parametrium or vagina—will actually be Stage III cases. In spite of the historically poor results in cases with cervical involvement, these Stage II cases can be relatively effectively managed if anticipated. (Clearly, it won't be anticipated if the sole diagnostic procedure has been an office endometrial biopsy revealing adenocarcinoma).

This is where the fractional part of the fractional D & C comes in. Tissue obtained from careful curetting of the cervical canal first, and from multiple cervical biopsies is saved separately from the tissue obtained by curetting the endometrial cavity. If cancer involves the cervix, simple hysterectomy only, is totally inadequate. This cancer, whether arising there, or spread there, has picked up the potential spread pattern of cervix cancer (Figure 1-II). It is not important that it is "squamous cell" or "adenocarcinoma." The biological fact is that this is cancer involving the cervix.

ROLE OF RADIATION

Because these patients are usually older, heavier, and more subject to medical problems, such as diabetes and hypertension, standard practice advises radiation, as for cervix cancer, and usually the addition of simple total hysterectomy

TABLE 5

VAGINAL RECURRENCE DATA

(Modified after Moss and Brand[9])

	Hysterectomy Only		*Preoperative Radium*	
Author	NO. CASES	PER CENT VAGINAL RECURRENCE	NO. CASES	PER CENT VAGINAL RECURRENCE
Rickford (1949)	23/160	14.4		
Way (1951)	14/102	13.7		
Dobbie (1953)	7/64	11.0	2/84	2.4
Gusberg (1960)	11/121	9.1	2/170	1.1
Stander (1956)			1/103	1.0
Sala (1962)			3/68	4.0
Price (1965)	6/41	14.0	4/110	3.6
Copenhaver (1965)	14/141	10.0		
Wade (1967)	4/43	9.3	3/156	1.9
Totals	79/672	12.0%	15/691	2.2%

TABLE 6

ENDOMETRIAL CANCER TREATMENT RESULTS

(Modified from Gusberg et al[3])

Author	*Hysterectomy Only* NO. CASES	PER CENT 5 YEAR SURVIVAL	*Preoperative Radium* NO. CASES	PER CENT 5 YEAR SURVIVAL
Masson	306	66.6		
Bastiaanse	250	66.9		
McKelvey	94	73.0	95	74.0
Marshall	31	90.0	48	88.0
Payne	46	80.4	28	92.9
Miller and Henderson	20	53.3	16	86.6
Speert and Peightal	95	48.0	39	54.0
Palmer			30	80.0
Waterman			67	61.0
Corscaden	62	54.0	127	68.5
Webb, Margolis and Traut	43	65.0	49	71.0
Scheffey	16	62.5	46	91.3
Cosbie	68	63.2	47	70.2
Randall	30	60.0	98	81.6
Ingersoll and Meigs	124	58.8	89	65.2
Sandberg and McLennon	39	92.3	22	90.9
Schmitz			26	65.4
Kamperman	14	57.1	29	86.1
Sherman and Arneson	57	70.0	91	72.5
Taylor and Becker	17	64.7	31	64.5
Leucutia	71	47.4	64	81.2
Hundley			32	84.0
Brindley			24	79.0
Kottmeier			48	72.0
Totals	1,383	64.0%	1,146	76.5%

at the completion of radiation to remove potential residual disease in the myometrium. If the patient is a suitable candidate and a pure surgical treatment is considered preferable, then one would elect a Meigs-Wertheim type radical hysterectomy and pelvic node excision as the operation of choice. An occasional case will be selected for radium and radical hysterectomy.

Stage I. The disease is confined to the body of the uterus. These cases constitute at least 75 per cent of the cases seen. It is in this group that the debate of "hysterectomy" vs. "preoperative radiation" has raged most heatedly. It does seem from available data (Table 5) that post-treatment vaginal recurrences are fewer, in series where preoperative uterine and vaginal radium was used, compared to those treated by surgery alone. This is a principal consideration in the case for routine preoperative radiation. However, in spite of several very thoughtful studies,[3, 4] the overall cure rates among preoperatively radiated series don't appear to differ appreciably from those in series treated by surgery alone (Table 6), and the case is somewhat weakened.[3–6] When a woman with Stage I disease becomes a treatment failure and surgery alone was used, the relative merits or lack of merits of the treatment plan are of little consolation to anyone.

STAGE I CANCERS

However, Stage I cancers (confined to the corpus) occur in several varieties such as uterine size and depth and histologic differentiation. The data of Gusberg et al[3] suggest that the small uterus, normal for the age and parity of the patient, with well-differentiated cancer, may be equally well treated with hysterectomy, with or without preoperative radiation. However, once there is departure from these criteria, the equality of treatment modes fades. It is clear that uteri enlarged by tumor, or uteri with poorly differentiated tumor, have less favorable prognoses, and preoperative radiation seems most reasonable.

One study supports the clinical value of this combined approach.[3] Equally clear, is the necessity to use combined therapy or properly executed radical surgery for Stage II cases. And, of course, accurate and thorough pre-treatment assessment is absolutely essential for proper staging. Finally, with disease spread beyond the uterus, the patient's only hope is combined therapy.

TABLE 7

TREATMENT PLANS

Stage I	(1) Uterus normal size for age and parity; and well differentiated cancer (a) surgery alone or (b) preoperative vaginal and uterine radium (+) or (c) preoperative whole pelvis irradiation (*) (2) Uterus enlarged or tumor histology less than "well differentiated" (a) preoperative vaginal and uterine radium (+) or (b) preoperative whole pelvis irradiation (*)
Stage II	(1) Subclinical cervical involvement (a) uterine and vaginal radium as for Stage I, then hysterectomy or (b) preoperative whole pelvis irradiation as for State I, then hysterectomy or (c) primary radical hysterectomy and pelvic lymphadenectomy (2) Clinical cervical involvement (a) treat with radium and external beam therapy as cervix cancer, then add conservative hysterectomy or (b) primary radical hysterectomy and pelvic lymphadenectomy
Stage III	Treat as cervical cancer of comparable clinical findings. Add hysterectomy rarely, only selectively.

(+) Uterine radium, at least 5000 mg. hrs.; vaginal radium, at least 6000 r. surface dose

(*) Total pelvis 4500-5500 r. midplane dose

Widely accepted treatment plans for each stage of endometrial adenocarcinoma are summarized in Table 7. This is based upon material in this discussion as well as views of others.[7-9]

SUMMARY

The anatomical, biological and clinical data relating to adenocarcinoma of the endometrium are presented. The importance of pre-treatment diagnostic steps and clinical staging are emphasized. Surgical and radiotherapeutic techniques singly, and in combination, are discussed. Utilizing this information, a plan of therapy for the varied clinical manifestations of this disease is presented.★★★

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Glaucoma Therapy Simplified

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GLAUCOMA IS A DISEASE described by Hippocrates in 400 B.C. The first modern descriptions of this disease were by William MacKenzie in 1830, and Von Graefe in 1854. The first iridectomy for treatment of glaucoma was also performed by Von Graefe in 1856. Although our knowledge of the disease has increased by logarithmic proportions since that time, there are still many problems in the management of the typical patient, and it is the purpose of this paper to resolve some of these difficulties.

The two texts that most adequately describe the disease, its treatment and ramifications today are Chandler and Grant, "Lectures on Glaucoma,"[1] and Becker and Shaffer, "Diagnosis and Therapy of the Glaucomas."[2] The material presented in this paper represents the patient experience of the Satellite Eye Clinic of The University Medical Center in Greenville, Mississippi, where over 800 complete glaucoma workups have been performed in the past year.

Glaucoma is a disease defined as the presence of an intraocular pressure sufficient to cause functional or structural damage in the eye resulting from that pressure. This is the first dilemma, identifying those eyes with a pressure elevation, which, if untreated, will yield intraocular damage. Some authors feel that a treatable disease is not actually present unless there is a characteristic glaucomatous field defect present.[3] It is my feeling that it is possible to find patients who will develop optic nerve damage by doing a careful diagnostic evaluation in those patients with an applanation pressure above 21 mm., a Schiotz pressure above 22 mm., or an abnormal response to the Harrington Flock's screener. The numbers indicative of abnormal pressure merely represent the mean pressure, plus two standard deviations on a normal population and could conceivably change with additional population studies.

The diagnosis of glaucoma and its classification are reviewed, using some of the newer diagnostic tools. Based on the patient experience of the Satellite Eye Clinic in Greenville, Mississippi, the author gives his approach to diagnosis and therapy of the glaucomas.

The number of glaucomatous diseases is quite large and some are unrelated to any other ocular disturbances, while a large number are secondary to other ocular pathology. There are two main classifications of the glaucomas in use today, that of Sugar,[4] and Becker and Shaffer.[1] Both merely serve as a tool to guide therapy. Both require anatomical evaluation of the angle of the anterior chambers of the eye by gonioscopy.

Gonioscopy is a method of examination of the angle of the anterior chamber of the eye utilizing a contact glass to eliminate the total internal reflection that occurs in the cornea. It can be performed with any number of lenses that require indirect viewing (through a mirror or prism) or direct viewing with a slit lamp or a hand-held microscope. The manner of insertion and observation through the lens is described in Becker and Shaffer and there are photographs of the normal and abnormal appearing angle. I prefer

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the Koeppe lens with a hand-held microscope because of the ease with which the examiner can view various areas, and because it can be used in the operating room for the evaluation and treatment of angle closure glaucoma or infantile glaucoma.[5-7]

When performing gonioscopy, all portions of the anterior segment are observed. I usually start by looking at the lens and pupillary border and then moving fixation across the iris to the angle. The normal angle reveals Schwalbe's line, the trabecular meshwork (which overlies Schlemm's canal), the scleral spur (which is the anterior insertion of the ciliary body) and iris processes. At times there is blood present in Schlemm's canal in the normal eye, usually when the intraocular pressure is below the episcleral venous pressure (11 mm.).When observing the angle, an estimate is made of the depth of the anterior chamber with the closed angle being given the designation grade zero and the wide open designated grade four. Also, an estimate of pigment on the trabeculum should be made. This is graded as zero (for no pigment) to four for maximal pigment as seen in pigmentary glaucoma.

ANGLE ABNORMALITIES

Gonioscopy should be done in every eye with an elevated pressure to immediately decide whether the angle is closed, and requires immediate surgical treatment, or open and medical therapy should suffice. Those angles not closed but narrow probably have a combined type of glaucoma and require extreme caution in the use of epinephrine type drugs or strong miotics. Gonioscopy, in addition, is useful in identifying numerous other abnormalities associated with specific types of glaucoma. These secondary glaucomas with gonioscopic abnormalities are listed in Table I. In addition, gonioscopy is useful preoperatively in identifying things like aberrant blood vessels which could be responsible for postoperative Hyphemas. This does not mean that all secondary glaucomas are detected with gonioscopy. There are many other secondary glaucomas that are diagnosed by a complete ophthalmic examination and an awareness by the clinician of their causative nature. These secondary glaucomas are enumerated in Table II.

TABLE I

SECONDARY GLAUCOMAS ASSOCIATED WITH ANGLE ABNORMALITIES

Angle Closure from Swollen Lens	Pigmentary
Posterior Synechaie	Pseudoexfoliation
Recession of the Angle	Aniridia
Subluxated Lens	Sturge Weber
Malignant Glaucoma	Neurofibromatosis
Neovascularization or Rubeosis	Marfan's
Essential Iris Atrophy	Axenfeld
Trauma	Spherophakia
Anterior Synechaie	Microcornea
Iris Tumors	Debris in Angle
Epithelial Downgrowth	Cysts of Iris or Ciliary Body
Vein Occlusion	Lowe's Syndrome
	Rubella Syndrone
	Xanthogranuloma

TABLE II

SECONDARY GLAUCOMAS WITHOUT ANGLE ABNORMALITIES

Trauma	Increased Venous Pressure (e.g. Tetralology of Fallot)
Inflammation	Aminocystinuria
Tumors	Retrolental Fibroplasia
Retrobulbar Pressure	Posterior Segment Hemorrhage
Epidemic Dropsy	Glaucomato-Cyclitic Crisis
Drugs (Steroid, Alpha Chymotrypsin)	Ruptured Lens
High Myopia	Ridley Implant
Retinal Detachment	Choroidal Angioma
Fuch's Dystrophy	Congenital Interstitial Keratitis
Retinitis Pigmentosa	
Hypersecretion	

Once we have excluded the closed angle and secondary types of glaucomas, we are left with the simple or chronic open angle type of glaucoma. This is the type in which we also have the most difficulty in actually establishing the diagnosis in patients with borderline pressure, and in determining which patients should be treated despite the absence of obvious structural disturbances. I have tried to establish a criteria similar to the Jones Criteria of rheumatic fever[8] in which a patient is considered to have glaucoma if he has two majors; or a major and two minors (as illustrated in Table III). The tests used in the minors are discussed in various glaucoma texts, and only a brief comment on them will be made.

In this criteria it is important to note that applanation tonometry is stressed over the Schiotz tonometer because of its greater accuracy. The applanator depends upon determining the force required to flatten a standard area of cornea (3.06 mm.). It does not displace much intraocular fluid (0.5 ul.) as does the Schiotz tonome-

ter, nor does it increase the pressure of the eye so that it gives readings almost independent of ocular rigidity.

Use of this simple instrument, which takes perseverance and practice, once mastered, is simple, more rapid, and easier for the patient to accept than the Schiotz tonometer. In addition, most young ophthalmologists and glaucoma experts are beginning to use applanation tonometry exclusively. Applanation tonometry allows the physician to rapidly eliminate patients with high scleral rigidity who have an elevated Schiotz tension but do not have glaucoma. Of paramount importance, however, are the patients with low scleral rigidity who show normal Schiotz readings, but actually have elevated intraocular pressure. These include myopes, patients with hyperthyroidism, patients who have had retinal detachment surgery, and patients who have been on long-term miotics.

TONOMETRY TECHNIQUES

The technique of applanation tonometry is not difficult and just requires practice to attain proficiency. It is described in the standard glaucoma texts and an adequate movie describing the technique can be obtained from and/or shown by the Ayerst Laboratories Representative.[9] Briefly, following a local anesthetic the tear film is made fluorescent. The patient is at the slit lamp which has an applanator. The blue filter is used and the tonometer prism is moved forward until it just touches the eye with the joy stick. Two semi-circles are then seen and the microscope is adjusted so the circles are equal in size (raising or lowering). The knob is then turned until the two semicircles just touch their inner edge on each pulsation. I usually take three readings and accept the third as the most accurate to eliminate elevation from patient apprehension.

In order to evaluate the optic disc, I use photos every six months to one year for comparison evaluations. Otherwise, there must be what I consider a classic glaucomatous cup to be accepted as a major. In addition, the presence of a cup almost always indicates that a glaucomatous field defect is also present.

I consider any defect the nature of a nerve fiber defect, a paracentral scotoma of greater than 5°, or a nasal step of greater than 10° without obvious cause as a major finding and diagnostic of glaucoma when associated with an elevated tension or glaucomatous cup.

Fields less than this and discs merely suspicious are considered under minor categories. In the minor group are also included the various diagnostic tests used in detecting glaucoma. The water test requires the patient be NPO for six hours and given a liter of water and his tension measured every 10-15 minutes for one hour. A rise of 9 mm. or greater is considered as positive. This test, tonography, and the suction cup test all depend on the principle that if in a normal eye the intraocular pressure increases, the rate of the aqueous outflow also increases. In a glaucomatous eye, however, the aqueous outflow does not increase resulting in a pressure rise on the water test, a flat tracing on tonography, or a delay in the fall back to normal in the case of the suction cup. I combine tonography with the water test and run the tonogram one hour after drinking the water.

TABLE III

KNOPF CRITERIA FOR DIAGNOSING GLAUCOMA

(Two Majors; One Major and Two Minors)

MAJORS

Elevated Applanation Pressure (more than 21 mm.)

Evidence of Progressive Change in Optic Disc, or Disc Absolutely Diagnostic of Glaucoma

Evidence of Progressive Glaucoma Field or Field Absolutely Diagnostic of Glaucoma (nerve fiber defects, Paracentural Scotoma over 5°, nasal step over 10°) without obvious explanation

MINORS

Disc Suspicious of Glaucoma (Weak)

Field Suspicious of Glaucoma (enlarged B.S., baring a the blind spot)

Abnormal Water Test (more than +9 mm.)

Abnormal Tonography

Positive Family History

Positive Downey's Sign (4 mm. difference)

Elevated Schiotz Pressure if Applanation not Performed

Perilimbal Suction Cup (return to normal in 15 minutes)

Other Laboratory Type Tests:

Pressor Test	Priscoline Test
Caffeine Test	Bulbar Pressure Test, of Baxter
Anterior Chamber Puncture	
Test	

FAMILIAL TENDENCIES

The family history is extremely important and probably deserves more value than just being a minor. Patients diagnosed as having glaucoma should be made aware of this strong familial tendency so that their children, parents and siblings can be brought to an earlier diagnosis.

Downey's sign is merely a difference in tension between the two eyes of 4 mm. without an obvious explanation.

Schiotz tension is included here merely for those who do not use applanation tonometry. If Schiotz is performed, it should be done with several weights in an effort to detect abnormal scleral rigidity. The other mentioned tests, which I do not perform, are mentioned merely for their academic value.

The medical treatment of glaucoma demands a limited knowledge of the pharmacologic action of the drugs. The topical drugs fall into the three main groups: The parasympathomimetics, choline esterase inhibitors, and sympathomimetics.

The parasympathomimetics (or those drugs that mimic acetyl choline) are represented by pilocarpine and carbichol. They act by some unknown mechanism that increases the outflow of aqueous. This action is unrelated to the miosis so that Neosynephrine can be given with one of these drugs. The duration of action of pilocarpine peaks at 3-5 hours, thus dictating a dosage of 4 to 6 times a day.

CHOLINE INHIBITORS

The choline esterase inhibitors, represented by Phospholine Iodide, act by destroying choline esterase and allowing acetyl choline to build up at the motor end plates, producing a profound miosis. It is important to note that the stronger of these drugs develops competitive inhibition with pilocarpine and produces a weaker action than if either drug is used alone. This occurs because pilocarpine and acetyl choline work at the same site.[10–12] Eserine, a milder choline esterase inhibitor, works synergistically with pilocarpine, however. The strong miotics cause congestion and should not be used in the presence of narrow angles. They should be discontinued approximately one week prior to glaucoma surgery to avoid iritis and an immobile pupil.

The choline esterase inhibitors have systemic effects which can be extremely hazardous in a patient whose serum choline esterase level is depressed from other agents—insecticides, for example. Also, patients on them may develop a profound respiratory depression if given succinyl choline during general anesthesia. If necessary, the actions of these drugs can be reversed by Protopam (Ayerst), atropine and artificial respiration. Finally, recent evidence is being accumulated to show that the strong miotics may cause cataract formation.[13–16]

The sympathomimetic, or epinephrine type drugs, act by decreasing the production of aqueous in addition to increasing the outflow. They act synergistically to the miotics. The duration of action of the drugs is 12-16 hours, dictating a b.i.d. dosage. Recently a number of products have been released offering a combination of epinephrine and pilocarpine in one bottle. It should be kept in mind, however, that some investigators feel that the combined drug gives less of a therapeutic response than either drug used individually.[17] In addition, combined products require that the patient either gets epinephrine too frequently, increasing the risks of pigmentation of the cornea and conjunctiva, sensitivity and macular edema; or that the pilocarpine is not given frequently enough for a therapeutic response. The epinephrine drugs should be used with caution in the presence of narrow angles.

Carbonic anhydrase inhibitors are oral agents that act by depressing aqueous production. There are a number of products available, and they are of equal potency on a tablet for tablet basis (disregarding the mg. dosage). An adequate dosage is one tablet, four times a day. This group of products is used in addition to the topical drugs. It should be kept in mind that the carbonic anhydrase inhibitors may cause potassium depletion, requiring supplemental potassium. They may also cause renal calculi, and I would suggest giving a drug to acidify the urine in any patient with a history of calculi. Other significant side effects include paresthesia, abnormal taste (for carbonated beverage in particular), drowsiness, fatigue, gastrointestinal disturbances, fever, allergic skin reaction and bone marrow depression.

The other agents used to reduce intraocular pressure include drugs like glycerol, mannitol, and urea. These drugs act because of their osmotic effects and are usually used for an acute attack of glaucoma or preoperatively.

CHRONIC THERAPY

With the mechanism of action of the various pharmacologic agents in mind, the therapy of chronic simple glaucoma becomes greatly simplified. The goal of the therapy is to stop progression of the disease as manifest by changes in the optic nerve or on visual fields. This objective is usually reached by keeping the tension within the normal range, but should be evaluated by visual fields and fundoscopy at reasonable intervals.

Patients newly diagnosed as having open angle glaucoma, I start on 1 per cent Pilocarpine, four

to six times a day. If this is insufficient, the dosage of Pilocarpine is increased to either 2 per cent or 4 per cent. I feel that there is no benefit to be gained by increasing the dosage greater than 4 per cent, although others disagree.[18]

If 4 per cent Pilocarpine proves inadequate, I add an epinephrine type drug twice daily. If this proves ineffective, Eserine (Physostigmine) ointment ¼ per cent at bedtime is added to the Pilocarpine, q.i.d., and epinephrine, b.i.d.

If you suspect Pilocarpine resistance, or the patient is sensitive to Pilocarpine, Carbachol may be substituted at one-half the percentage of the Pilocarpine.

If a combination of pilocarpine, Eserine and epinephrine fail to control the pressure, this therapy is discontinued and an attempt made to obtain control with Phospholine Iodide, 0.125 per cent, b.i.d., or an equivalent cholinesterase inhibitor. If this is insufficient, then epinephrine is added, b.i.d.

Failure to control the pressure with this regime leaves the ophthalmologist with no choice but to add a carbonic anhydrase inhibitor. If a strong miotic, epinephrine, and a carbonic anhydrase inhibitor fail to control the tension, then surgery becomes necessary unless the visual field is so poor that surgery will cause a "snuff out." Some practitioners feel there is no place for long-term carbonic anhydrase inhibitors and operate when the need for these drugs becomes manifest.

SURGICAL PROCEDURES

There is little to be said about the choice of surgical procedures. That procedure which works best for each individual surgeon is probably most appropriate. The most nasal position that can be used should be selected for the site of surgery to allow the superior and temporal areas for additional procedures or a subsequent cataract extraction. Filtering procedures are done for phakic patients, and cyclodialysis for aphakic patients. When doing a filtering procedure on young children or negro patients, I excise a small piece of Tenon's capsule.

Patients with glaucoma requiring surgery and cataracts may be treated by any one of three possibilities: Remove the cataract first, followed by glaucoma surgery at a later date; perform a combined procedure; or do a filtering procedure first and remove the cataract later with an incision either inferior, in front of, or through the bleb. I prefer to do the filtering procedure first in a nasal superior position and to remove the cataract later from the side and below.

This therapeutic regimen is not rigid and can be varied for different patients. Some young patients cannot tolerate pilocarpine because of its effects on accommodation, and for these patients control can be obtained by using a strong miotic at bedtime and epinephrine in the morning. I find aphakic patients tolerate strong miotics well and usually for patient convenience institute therapy initially with one of these drugs. Some special types of open angle glaucoma, particularly those with plugging of the trabeculum (such as pigmentary glaucoma), respond better to epinephrine type drugs and these should be used initially. ★★★

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Venomous Snakebites: Fiction Versus Fact

HENRY M. PARRISH, M.D., Dr. P.H.
Vermillion, S. D.

THERE IS A VAST amount of misinformation about snakebite accidents. It has only been in the past 20 years that medical scientists have studied this problem in detail. The purpose of this article is to provide the reader with information about venomous snakebites so he can separate fiction from fact.

FICTION—Snakes kill more people annually in the United States than any other venomous animals.

FACT—In terms of causing fatalities, snakes are not the most dangerous venomous animals in the United States. Of 460 fatalities from venomous animals during the 10-year period, 1950-1959, Hymenoptera insects (bees, wasps, yellow jackets and hornets) killed 229 people; snakes—138 people; spiders—65 people; scorpions—8 people; venomous marine animals—2 people; and unidentified venomous animals or insects—18 people.[1] While a bee sting is not life-threatening to the average person, it may produce anaphylaxis and/or death to a person allergic to its venom.

Of 138 persons killed by venomous snakes, 94 died from rattlesnake bites, 8 from cottonmouth bites, 3 from bites by foreign venomous snakes, and 2 from coral snake bites. Since that time there have been several fatalities from copperhead bites.

FICTION—Most species of snakes in the United States are venomous and, therefore, are dangerous to man.

FACT—Of the species of snakes native to the United States, only about 10 per cent of them are venomous.[2] Most of the venomous snakes in this country are pit vipers, so named because of a tiny pit located between the eye and nostril on each side of the body. The pit vipers include 15 species of rattlesnakes, 1 species of copperheads and 1 species of cottonmouths. The only other venomous snakes are 2 species of coral snakes. Thus, there are 19 species of venomous snakes in the United States. Every state except Maine, Alaska, and Hawaii has one or more species of venomous snakes.

There is a tremendous amount of erroneous information about venomous snakebites. Patients often ask physicians questions about snakebites. This paper separates fiction from fact for the following questions. Are snakes the most dangerous venomous animals in the United States? What is the most dangerous snake? Can a cottonmouth inflict a bite while it is submerged? Do bites by venomous snakes always leave two fang punctures? Is it true that a high percentage of snakebite victims die? Does a bite by a venomous snake provide permanent immunity? Do children have excessively high case-fatality rates from snakebites?

FICTION—The most dangerous venomous snake in the United States is the coral snake.

FACT—There are many definitions of "the most dangerous snake" including the snake whose venom is most toxic drop for drop, the snake which inflicts the most bites on people, and the snake which kills the most people annually. Figure 1 shows the venomous snakes of the United States.

Office of the Dean, School of Medicine, University of South Dakota.

It is true that drop for drop the coral snake has the most lethal venom of any venomous snake in the United States.[3] However, the coral snake produces only a small amount of venom, it has short fangs, it is not very aggressive, it is native to only 11 states in the southeastern and southwestern areas of the United States, and it bites only about 20 to 25 people a year. A study of 11 representative coral snake bites showed that 8 produced no venenation, 2 produced moderate venenation, and 1 resulted in severe venenation.[4] From 1950 through 1959 there were 138 snakebite deaths in the United States, of which, only 2 were inflicted by coral snakes. I rate large rattlesnakes species as the most dangerous venomous snakes in this country.

FICTION—A cottonmouth can't bite a person while the snake is under water.

FACT—The cottonmouth, sometimes called "cottonmouth moccasin," can bite a person while it is submerged. Numerous case histories are on file to attest to this fact. These aquatic venomous snakes feed on fish, turtles, frogs, and salamanders which the cottonmouth may bite and capture while submerged. Of course, cottonmouths also can inflict fang wounds when their heads are out of water either while swimming or on land.

FICTION—Texas has the highest annual snakebite rate in the United States.

FACT—While it is true that Texas has many species of venomous snakes and about 1,400 snakebite accidents a year, one must remember that Texas has a large human population. The best way to determine the extent of the snakebite problem of a state is to calculate the number of

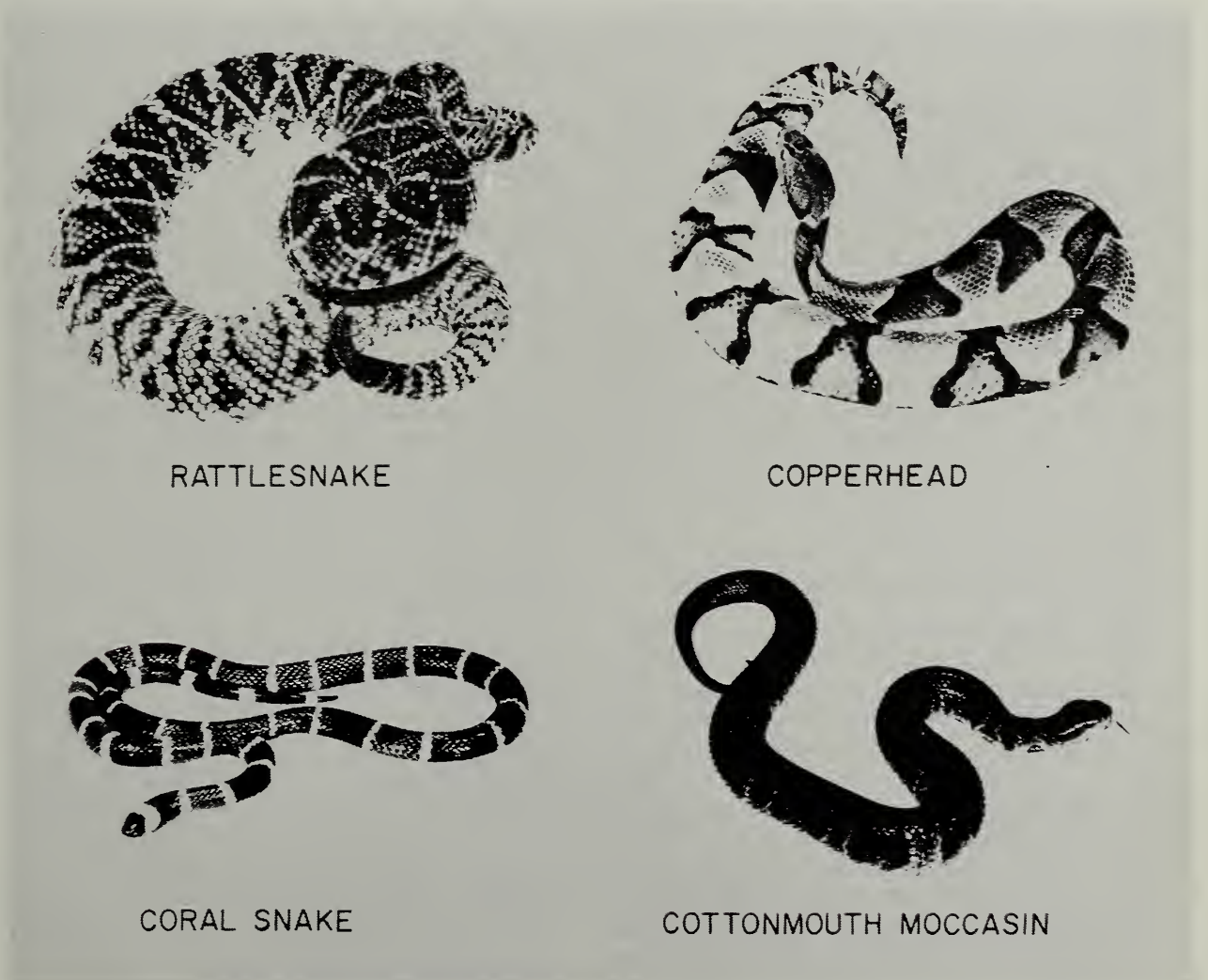


Figure 1. The four most venomous snakes native to the United States.

bite accidents per 100,000 population per year. Using this measurement, the states with the highest incidence of snakebites are: North Carolina—18.79; Arkansas—17.19; Texas—14.70; Georgia—13.44; West Virginia—11.29; Mississippi—10.83; and Louisiana—10.25.[5]

A measure of the seriousness of a state's snakebite problem is the average death rate from snakebites per million people. States having the highest average death rates are: Arizona—0.63; Georgia—0.60; Florida—0.54; Alabama—0.45; South Carolina—0.31; and Texas—0.27.[1] These are states which harbor species of large rattlesnakes. The fact that North Carolina has a high incidence of snakebite accidents but a low snakebite death rate results from most bites being inflicted by copperheads. They are much less deadly than rattlesnakes.

FICTION—Venomous snakes always inflict two fang puncture wounds when they bite a person.

FACT—A venomous snake usually bites a person when the snake is disturbed, handled, or stepped on. Under these circumstances the bite usually is an instinctive, defensive reaction rather than a planned bite such as when the snake is securing food.

Victims of snakebite accidents may present a variety of tooth marks and fang punctures. There are case histories of people being bitten two or three times or more by the same snake. Of 68 people bitten by rattlesnakes, 23 showed one fang puncture, 38 showed two fang punctures, 3 had three fang punctures, 3 had four fang punctures, and 1 had five fang punctures.

FICTION—Everyone who is bitten by a venomous snake develops venom poisoning.

FACT—As paradoxical as it may seem, it is possible for a venomous snake to bite a person without injecting enough venom to produce signs and symptoms of venom poisoning. This accounts for about 30 per cent of all bites by venomous snakes in the United States.[6] Formerly, it was thought that if a person showed no signs and symptoms of venom poisoning he must have been bitten by a harmless snake. Today we know he may have been bitten by a venomous snake. This unusual phenomenon is not completely understood at the present time, but it may result from an indirect hit by the snake's fangs, from the snake having empty venom glands from recent feedings, from broken fangs, or for some other unexplained failure of the venom gland-fang mechanism. Dr. H. A. Reid of the Liverpool School of Tropical Medicine has reported similar findings for cobra bites.[7]

FICTION—Of people bitten by venomous snakes, a high percentage die even with treatment.

FACT—An estimated 6,680 people are bitten by venomous snakes annually in the United States, yet an average of only 14 people die from this cause each year.[5] Thus, of those bitten, less than one-fourth of one per cent die. This is a remarkably good record. Most of those who died delayed in seeking medical treatment or received inadequate amounts of antivenin.

FICTION—Most snakebite accidents occur in the woods or in uninhabited places.

FACT—There is a place pattern for bites by various species of snakes in the United States. For example, about 55 per cent of copperhead bites happen on the victims' immediate premises (in their own yards or in, under, or on the porch or patio of a building). About 60 per cent of cottonmouth bites happen in or near water and another 20 per cent are in the victims' own yards which probably were located near water. The pattern of places where rattlesnake bites occur is more diversified. About 27 per cent are in the victims' own yards, 35 per cent are in fields and on farms away from the house, 14 per cent are in or under buildings, 13 per cent are in the woods and 5 per cent are on or near roads. The remaining 6 per cent happen in a variety of places. Also most coral snake bites happen in inhabited places while people were handling the snakes or while picking up boards or logs from the ground, or while working in their gardens.

FICTION—Since many species of venomous snakes feed at night, most snakebite accidents occur after dark.

FACT—Snakebites result from an interaction the characteristics of snakes, the activities of man, and environmental circumstances. The majority (86 per cent) of snakebite accidents happen between 6 a.m. and 8:59 p.m., which is the period when people are most active out-of-doors. Most people, especially small children, simply do not have much exposure to the possibility of a bite after dark.

FICTION—Few bites by venomous snakes are inflicted above the victims' knees.

FACT—A large rattlesnake can strike from the ground to above an adult's knee, but they do so

rarely. However, many people are bitten while handling a snake or engaged in activities other than walking. About 60 per cent of bites by venomous snakes are inflicted on the victims' lower extremities, 38 per cent on the upper extremities and the remaining 2 per cent on the head, face and neck or trunk of the body.[5] Most bites on the upper extremities are below the elbow and most bites on the lower extremities are below the knee. It is interesting that more bites are inflicted on the right side than on the left side of the body.

FICTION—Most snakebite victims who die do so in the first two hours following the bite.

FACT—Many people erroneously believe that victims of venomous snakebites are at a high risk of dying within a few minutes up to two hours after the bite. This simply is not true for snakes found in the United States. Usually the venom is deposited into the subcutaneous tissues of the victim, since even a large snake's fangs are less than an inch long. It usually takes several hours after a snakebite before the full toxic effects of the venom become evident. Of 138 people who died from snakebites in the United States during a 10-year period, only 4 per cent died within 1 hour and only 17 per cent died within 6 hours. The majority (64 per cent) died 6 to 48 hours after the bite.[1] Any snakebite victim who can obtain medical help within two hours following a snakebite has a very good chance for survival. Above all else, victims should not drive recklessly to the hospital as there is a greater risk of dying from an automobile crash than from a snakebite.

FICTION—Hunters and their dogs run a high risk to snakebite accidents.

FACT—Relatively few hunters and their hunting dogs are bitten by venomous snakes. In most states the hunting season does not begin until about October; whereas most snakebite accidents among human beings and dogs happen between April and September. Moreover, most hunters wear boots and heavy trousers which prevent many snakebites. During the colder months of the year snakes are less active or are hibernating. Actually, fishermen, summer campers, and hikers have a higher risk to being bitten by venomous snakes than hunters.

FICTION—One bite by a venomous snake provides permanent immunity against subsequent bites.

FACT—Many people, especially snake handlers, believe that if they survive one bite by a venomous snake, they develop permanent immunity against subsequent bites. This is not true![8] It is possible to immunize human beings against snake venoms, but they must receive frequent injections of venom to maintain a protective level of antibodies. If they stop taking these injections, their antibody titers decline to low levels after about three months. In snake venom poisoning there is a short incubation or latent period (5 to 30 minutes) from the time of the bite until symptoms appear. This does not provide sufficient time for a "boster effect" on antibodies such as is found in communicable diseases, like tetanus, where the incubation period is 6 to 14 days. A high level of antibodies must be present at the time of envenomation, or shortly thereafter, in order to neutralize the venom. While active immunization of human beings to snake venoms is possible, antivenin therapy would seem to be a much more rationale approach to this problem.

FICTION—Bites by venomous snakes are more lethal to children than to adults.

FACT—In theory one would expect children to have a higher case-fatality rate from snakebites than adults. If the same amount of venom was injected; children have smaller body weights than adults to counteract the venom. In the United States this hypothesis simply is not true in practice. This can be explained, in part, by the fact that children receive approximately the same dose of antivenin that adults received. The case-fatality rate for children less than 5 years of age is 1.5 per cent, the rate is extremely low for children 5-14 years of age. The highest case-fatality rates are found for adults 60-69 years of age (2.5 per cent) and those 70 or more years of age (6.7 per cent). No doubt other diseases, such as heart disease, in older persons are contributing factors to their deaths. ★★★

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Radiologic Seminar LXXXVIII: Ischial Apophysiolysis

T. S. McCAY, M.D.
Jackson, Mississippi

OUTGROWTHS OR projections of bones which do not have independent ossification centers (such as epiphyses of long bones) are called apophyses. One such apophyseal ossification center is that for the ischial tuberosity. This center appears between 12 and 16 years of age and fuses with the ramus of the ischium at about 21-25 years of age. The hamstring muscles of the thigh insert into these crescent shaped ischial apophyses. With violent muscular activity such as hurdling, jumping or doing "splits" these apophyseal centers are prone to avulsion during the period prior to fusion with the ischial rami.

Following injury these patients have localized tenderness over the area of the involved tuberosity (occasionally the lesions may be bilateral) and pain on flexion of the thigh with the knee extended. There will also be pain on active forceful contraction of the hamstring muscles.

X-rays of the pelvis will reveal the avulsed fragment providing there is sufficient ossification of the apophysis. In younger age group patients, since the apophysis is largely cartilaginous, the avulsed fragment may be much larger than that apparent on the radiograph. There may also be avulsion of a portion of the ischial ramus in addition to the apophysis. Later, as healing occurs callous formation will be noted, sometimes quite extensive, and radiographic changes may persist for several years.

In most cases these injuries are treated conservatively with good results. However, if separation of the avulsed fragment is quite wide surgical repair may be necessary.

Awareness of the existence of and appearance of these fractures is important since they may be mistaken for other conditions and inappropriately treated. As far as differential diagnosis is concerned, the conditions most likely to be confused with this entity are osteochondromas or other proliferative bone tumors, calcified hematomas, and calcification in an ischial bursa. Points of paramount importance in differentiating ischial apophysiolysis from the above conditions are—

1. history of the proper type of stress injury and

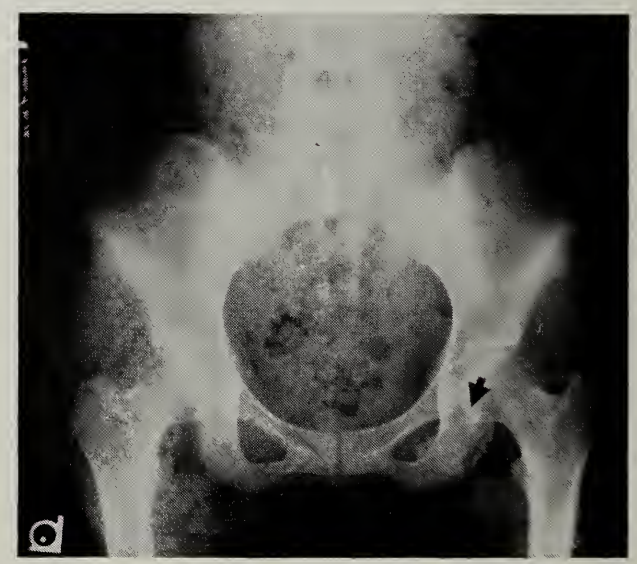


Figure 1. AP view of pelvis. Note fragmented, calcified mass overlying the right ischial tuberosity representing the avulsed apophysis and an ossified periosteal hematoma.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic Hospital.

2. demonstration of the actual avulsion by radiography. In order to show the avulsion good radiographs are necessary with proper projections and sometimes stereoscopic views are helpful.

The presented radiographs are those of a 19-year-old female in whom the lesion was an incidental finding on a film obtained for evaluation of the lumbar spine. History revealed that several years earlier while doing acrobatics as a cheerleader she had sustained a painful injury in the area of her right ischial tuberosity which was thought to be a "pulled muscle" and which responded to conservative treatment. At the time of this study the patient was entirely asymptomatic. ★★★

St. Dominic's Hospital (39216)

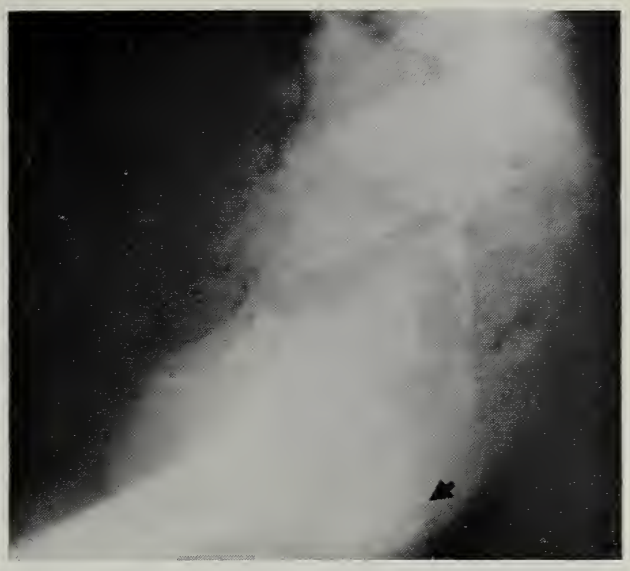


Figure 2. Lateral view of pelvis. Note radiolucent line between ischium and avulsed apophysis.

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FACTORY-REBUILT

Quite a few years ago a native from deep in the interior was brought to our Persian Gulf Hospital. His leg had been crushed under a huge rock. Once over the initial shock, he exhibited unusually good spirits. This was his first contact with white men and civilization. Even as simple a thing as turning on an electric light seemed a first-class miracle to him.

A few days after performing the necessary amputation, the doctor asked him, via an interpreter, how he felt. "Just fine," the patient answered. "The leg doesn't hurt a bit since you took it off. When will it be well enough to put back on?"

—William Duncan, M.D.



The President Speaking

'The Call Was Answered'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

IN THE RECENT HURRICANE disaster on the Coast, physicians, both as individuals and as an organization, demonstrated their ability and willingness to respond quickly. Many reports of heroic and selfless service by the physicians who live and work in the coastal area have been received. Their services during and immediately following the storm brought life saving measures to many victims.

Following emergency care, evacuation of patients to undamaged facilities was an immediate priority. Medical facilities all over the state opened their doors to receive the victims, flown out principally by the Air National Guard in their large planes.

Medical supplies and personnel were rushed to the disaster area, some on Sunday in anticipation of the storm, and more on Monday morning. On very short notice, the University Medical Center dispatched a team of 10 physicians, 10 nurses, and other allied personnel, together with a truck of supplies. A call was sent out by your state association for physicians to volunteer for service when and if needed in the disaster area, and the response was overwhelming.

These, and many other examples that could be told, demonstrate that medicine met the challenge of this disaster in the highest tradition of service to their fellowman. ★★★

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VOLUME X, NUMBER 10

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EDITORIALS

The United States Senate: No Place to Grow Old

I

SENATE: from the Latin *senex* and *senis,* elder or old, a noun denoting a council of elders. And in the first 56 Congresses during the first century of the republic's life, the United States Senate was indeed a council of elders. In the past generation, by sharp contrast, the life expectancy of our senior lawmakers has fallen significantly. Currently, it's much healthier to be a ditch-digger than a senator.

In a remarkably detailed study by Metropolitan Life Insurance Co. actuaries, it has been discovered that today's U. S. senator dies six years before other less prominent American males. A trademark of the 20th century crunch of public life, the senator has even less life expectancy than the President whose years are also declining (The Toll of the Presidency: A Shorter Life, J.M.S.M.A. IX:21-23 (Jan. 1968).

The study of the solons considered a significant sample, the 1,619 men elected or appointed to the U. S. Senate from the 1st Congress in 1789 through the 90th Congress in 1966. One out of six died in office, four were assassinated, three were killed in duels, and one was a casualty in the War Between the States. Nine women have served in the senate through 1966, but they are not considered in the study. And the JOURNAL is just as smart in that respect as the Metropolitan actuaries: We're not going to get into any hassles about women's ages, either.

II

Of the 1,619 senators, 1,416 died prior to 1966, 223 while serving in office. From the outbreak of the war in 1861 until 1930, their longevity was almost that of other American males. But over the long pull, 178 years to be exact, their mean life expectancy has been 1.3 years less than other men.

From and after 1861 to 1966, the 571 senators who took office show a life expectancy of 2.3 years less than other American males. By contrast, Presidents of the United States who served before Abraham Lincoln lived a third of a year longer than the average of the male population.

There was a short period during the latter part of the 19th century when some 392 senators lived on the average 0.6 year longer than fellow citizens, but this is an aberration in the mortality curve of these distinguished men. Overall, senators entering office since 1861 have been older upon taking the oath and have died sooner than the average of the male population.

It is noteworthy to take into account that a man must now be on the political scene longer to make the Senate than in years gone by. From the 1st Congress in 1789 until 1860, the mean

age of a freshman senator was 45.4 years. From the war until the turn of the century, he was 49.9 years of age. Since 1901, he has been 52.8 years of age.

The solon's declining lifespan has dropped from that of the typical American male to some 5.9 years less in 1966, and he may expect to die at or before age 69.

III

The 144 senators who took office after 1930 had the poorest longevity record of all, possibly reflecting the pressures and anxieties of the depression, World War II, the Cold War, Korea, Viet Nam, and the domestic crises faced today. The picture is really worse than the mortality tables make it appear, because senators are more often than not drawn from the higher socioeconomic brackets where the general mortality rate is almost 10 per cent better than that of lower social and economic levels.

This grim footnote is forcefully underscored by a study made in 1968 of men listed in the 1950 edition of *Who's Who in America*. They are enjoying mortality rates as much as 30 per cent below those for the white male population of the United States. And every senator is listed in *Who's Who*.

And, of course, there are always the exceptions to confound the rule. Two first-time senators were octogenarians upon taking office: Sen. Andrew Jackson Houston of Texas was 86 when he was elected in 1941, and he died after two months in office. In 1908, Sen. John Wolcott Stewart of Vermont entered office at age 82 and lived to be 90.

The record belongs to a Californian, Sen. Cornelius Cole, who was elected in 1867 at age 44. While he served only one six-year term, he lived to be 102 years of age. More recently, Rhode Island's Greene retired at 90.

IV

A sample of 1,600-odd American males considered over a span of 178 years, however accurately studied, will hardly enlighten the sciences of medicine and demography. But the findings are significant when compared to the growing lifespan of all Americans, the backgrounds of advantage from which the members of the world's most exclusive club come, and the succession of domestic and world events coinciding with their shortened lives.

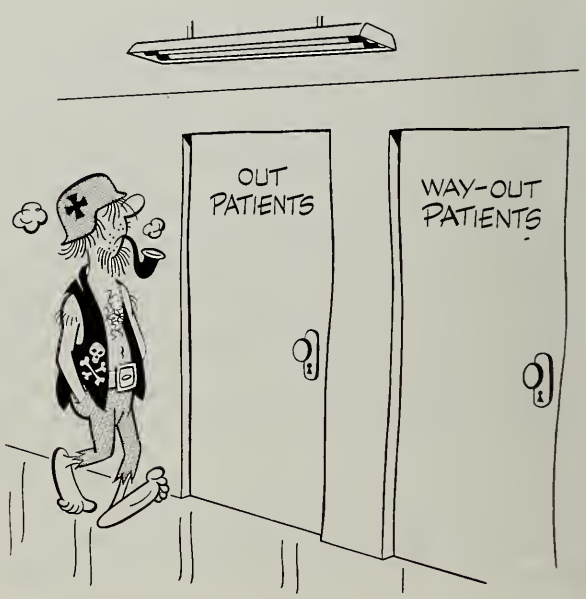
It goes without saying that the study has political connotations, too. The really powerful senators, the committee chairmen, are in their 60's, and if the findings have validity for the senior members of the 91st Congress, then we may reasonably expect them to move soon from the present political scene.

And it's difficult to equate the pressures of office to the poetry-reading McCarthy *vis-à-vis* the hard-working Hruska's, Stennis', Ervin's, Eastland's, and the rest. But somehow they all make up the mean. The toll of days exacted by prominence and public service has become progressively greater, and it is more than a passing matter of intellectual curiosity.—R.B.K.

Let's Make Medical Education Number One!

The loyalty of Ole Miss medical alumni easily matches the zealous fervor of her football rooters, and that's a pretty noisy mouthful. In 1968, Ole Miss received more money through the American Medical Association Education and Research Foundation than did 77 other medical schools. Only 19 surpassed her among the two and four year institutions.

But the most loyal Ole Miss medical alumnus will be quick to say that the cause is medical education first, and here's where AMA-ERF comes into focus. As the 1969 campaign kicks off, it is pertinent to remind ourselves that AMA-ERF is the doctor's own mechanism for supporting medical education in general and his own alma mater in particular.



Every penny received by AMA-ERF goes for the foundation's purposes. Not a cent is used for administration, advertising, or fund-raising, because AMA pays the full cost of the foundation's operation from its general funds.

Moreover, AMA-ERF money is precious currency to any medical school dean. He may use it as the needs of the school require, not as strings-attached, grant-restricted funds are inflexibly applied.

Mississippi physicians and members of the Woman's Auxiliary are the possessors of a proud record of generous support of medical education through AMA-ERF. On a per capita basis, they were well ahead of most of their American colleagues in 1968 giving. As the 1969 campaign begins, now is the time to think about shattering that proud record.

Of course, gifts to AMA-ERF may be earmarked for the medical school of the donor's choice or merely given to the general fund which is distributed among all the schools. Every cent is tax-deductible for federal and state income tax purposes.

As with food, automobiles, housing, and interest rates, the price tag on medical education is bigger than ever. Tuition rates are reluctantly being increased but not nearly in proportion to the overall costs of supplying quality medical education. The need has never before been greater nor the opportunity to help better.

Since 1969, personal disposable income has also shown a gain over 1968, let's make a little extra effort—and add an extra digit when writing that AMA-ERF check—this year. After all, it's a matter of making medical education *and* Ole Miss Number One.—R.B.K.

Injurious Sensationalism Over Medicare Fraud

Fraud, embezzlement, theft, and any like wrongdoing are to be deplored, however minor, because no reasonable and moral individual believes that there are degrees of sin. But mass media have sensationalized fraud under Medicare to a distasteful point. In the halls of the Congress and in the chambers of the Mississippi legislature, there have been grave and serious warnings of the need to protect the government and public from dishonest providers of medical services.

Medicare and, for that matter, every other public and private health care program, is virtually simon pure when it comes to misrepresentation and wrongdoing, let alone fraud. The cold facts on Medicare are proof enough of this:

—There are 19.3 million Americans eligible for benefits of Medicare.

—More than 200,000 American physicians have provided tens of millions of services under the program since its inception in 1965.

—Billions of dollars have been involved in Medicare.

But to date, there has been only one conviction of a physician, most regrettably in Mississippi, for fraud under the program. The Social Security Administration reports that 219 cases of possible misrepresentation, irregularity, or fraud are under investigation in seven southeastern states. Of these, 144 cases are in Florida with 10 in Alabama, 15 in Georgia, 15 in Mississippi, nine in North Carolina, six in South Carolina, and 20 in Tennessee.

And from the tens of millions of individual services rendered under Medicare, there are but 12 cases pending in the Department of Justice referred by SSA for prosecution. So it's forcefully apparent that fraud incidence and monetary loss in the program is less than employees of American business and industry take in company postage stamps. This is not in justification—merely in comparison, because taking a single stamp is also wrong.

Assuming Florida with its relatively high incidence of cases in comparison with other southeastern states to be an anomaly, then an extrapolation would indicate less than a thousand cases nationwide under investigation.

But the infinitesimal fraction of 1 per cent is and has been with us, furnishing a generous fallout of rub-off guilt on that the almost total numbers of sincere, honest physicians, hospitals, extended care facilities, and others providing services under Medicare. And while the facts show that irregularity under Medicare is but a single grain of sand along a mile of beach, let's do our part in rooting out any wrongdoing.

Let us be diligent in carrying out the association's policy of supporting utilization review by medical staffs. Peer control of health care programs is not only proper—it is also effective. It is a logical first step in ferreting out any obviously infrequent irregularity in which a physician might be involved.

And let none be deluded by the weight of statistics on the side of health care providers: It takes very little of this sort of wrong and deplorable thing to bring the wrath, however unjustly, of the Congress, executive department, and the public upon every member of the health care team.

Pertofrane® desipramine hydrochloride

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions: The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage: All patients except geriatric and adolescent. 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability: Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood... a restoration of psychomotor activity. Patients usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the respons

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available.

It's beautiful!



There's more, too. Let our agencies of government be a little more balanced and restrained in announcing the highly infrequent incidence of wrongdoing. The gleeful tone of the news release by the Atlanta regional Social Security office in the Conway case was not merely in poor taste—it was also injurious to that near-unanimity of physicians, institutions, and others who have done, are doing, and will continue to do an honest job of faithful service for their patients, either under or independently of Medicare.

The association calls for full prosecution under the law of anyone, be it beneficiary, provider, or practitioner, who perpetrates a fraud under Medicare or any other program. But there is equal if not greater responsibility to the honorable and diligent who seek what is right.—R.B.K.

New Progress in Care of Alcoholism

The association's Council on Medical Service, on recommendation of its Committee on Mental Health, has repeatedly called for recognition of alcoholism as a disease entity. It has called for admission of patients suffering from the disease to general medical and surgical hospitals for care in the acute phase and for voluntary prepayment and health insurance to cover this condition.

Progress in this difficult area where social stigma wrongly differentiates between "respectable" and "disrespectable" conditions has been slow and arduous. But at least one hospital has made notable progress, and it's a story worth hearing.

Since 1960, the Lutheran General Hospital at Park Ridge, Ill., has been admitting patients with alcoholism, caring for them in a special 38-bed unit. Recently, this unit was expanded to 73 beds. The hospital, working in close cooperation with the medical staff, bases the program on five major premises:

—Alcoholism is an illness and requires treatment as such.

—The treatment should attempt to promote the health of the total person, including physical, psychological, social, and spiritual aspects.

—The best course for many alcoholics is a short-term intensive concentration of treatment in the hospital with continued help following discharge.

—The treatment is a two-level program with the first part directed at the alcoholism addiction and the second part at the social and emotional aspects of living.

—Treatment is based upon conditions, and behavioral change is possible.

Lutheran General spokesmen say that the goals of the program are basically abstinence, behavioral change, promotion of interpersonal honesty and genuineness to gain acceptance and awareness of the needs of others and active involvement of the patient's family in the treatment program.

Once admitted to the treatment program, the patient is assigned a primary counselor whose function is to carry out the nonmedical treatment outlined by the attending physician. All primary counselors work under the direct supervision of the medical director and program director. Emphasis is placed on educating the patient about the nature of his disease.

Daily group therapy sessions are conducted, and where possible, the patient's spouse is encouraged to attend and participate. The marital relationship is emphasized and its preservation is uppermost among goals.

The $2.6 million facility was made possible at Lutheran General through corporate, organizational, and private gifts together with a $325,000 Hill-Burton grant, the first ever made for an alcoholism treatment facility. Isn't this a program worth emulating?—R.B.K.



"I think perhaps we'd better ease up on those hormone shots for a while, Mrs. Van Pewter."

Straining at a Gnat, Swallowing a Camel

The Department of Health, Education, and Welfare has strained at a gnat and swallowed a camel on Medicaid, says the AMA in so many words, and we couldn't agree more. The regulations placing severe limitations on physicians were attacked by AMA whose spokesman questioned whether HEW actually had the statutory authority to hand down such edicts.

Essence of the regulations is limitation of physicians' fees to the 75th percentile of usual and customary charges—not 75 per cent of the fee but rather what 75 out of 100 physicians in an area regularly charge.

"The regulation appears to reverse the roles of the state and federal government established in the law itself," said Dr. Ernest B. Howard, AMA executive vice president.

Dr. Howard said that the basic purpose of Title XIX (Medicaid) was to dissolve any barriers which existed between medical care available to the medically indigent and other (needy) citizens. He pointed out that the original law recognized that payment to participating physicians should be on the basis of reasonable, usual, and customary charges.

He said that the limitation imposed in the regulation departs from the statutory standard and "by establishing arbitrary limits on payments to individual practitioners, it should be recognized that the regulations may again raise a barrier to providing private care to the medically indigent."

And just to add a hearty second to the AMA protest, let's keep in mind that since Medicaid became operational on Jan. 1, 1966, *only 11 per cent of all federal and state funds involved in the program have been paid to physicians.* The other 89 per cent went to hospitals, nursing homes, pharmacists, and others providing supplies and services to program recipients.

Yet, incredibly, HEW is attacking that one penny out of nine involved in all of Medicaid.

Since the program has cost nearly half again as much as originally estimated, HEW could wipe out physicians altogether and still have a 39 per cent deficit!

This is the federal mentality in action. Spare us, please, from the big decisions.—R.B.K.

POSTGRADUATE CALENDAR

PULMONARY SEMINAR: THE BREATH OF LIFE

University Medical Center, Jackson
October 22, 1969, beginning at 9:30 a.m.

Sponsored by the University of Mississippi School of Medicine Postgraduate Education Committee and the Department of Medicine

Participants:

Alfred Brann, Jr., M.D., Assistant Professor of Pediatrics, University Medical Center

Patrick H. Lehan, M.D., Professor of Medicine and Mississippi Heart Association William D. Love Professor of Cardiology, University Medical Center

Ellis M. Moffitt, M.D., Clinical Assistant Professor of Medicine, University Medical Center

William A. Neely, M.D., Associate Professor of Surgery, University Medical Center

Donald Sherline, M.D., Associate Professor of Obstetrics and Gynecology and Instructor in Anesthesiology, University Medical Center

Hilary H. Timmis, M.D., Associate Professor of Surgery, University Medical Center

Myra Tyler, M.D., Assistant Professor of Medicine, University Medical Center

Watts R. Webb, M.D., Professor of Surgery, University of Texas School of Medicine at Dallas

Wednesday Morning

Resuscitation of the Newborn
Dr. Sherline and Dr. Brann

Emergency Airway
Dr. Neely

Spontaneous Pneumothorax
Dr. Timmis

Management of the Shock Lung
Dr. Webb

Wednesday Afternoon

Anaphylaxis
Dr. Moffitt

Smoke Gets in Your Airway
Dr. Webb

Acute Pulmonary Edema
Dr. Lehan

Acute Symptomatic Pulmonary Embolism
Dr. Tyler

POSTGRADUATE / Continued

CIRCUIT COURSES

Northern Circuit

Tupelo—October 21, November 18, North Mississippi Medical Center, 7 p.m.

Greenwood—October 23, October 30, November 6, Greenwood LeFlore Hospital, 7 p.m.

Session 1—Peripheral Vascular Disease
Angiograms, Dr. Hugh C. McLeod
Surgical Approach, Dr. Thomas L. Kilgore

Session 2—Diagnosis and Management of Rheumatoid Arthritis, Dr. Thomas E. Wilson, III
Anatomical Factors in Gall Bladder Surgery, Dr. Edward M. Lowicki

Session 3—The Diagnosis of Cardiac Disease
In Children, Dr. David Watson
In Adults, Dr. Patrick Lehan

Southwest Circuit

McComb—October 7, Southwest Mississippi General Hospital, 7 p.m.

Natchez—October 21, Jefferson Davis Memorial Hospital

Session 1—Renal Trauma
Management of Traumatic Rental Shutdown, Dr. John Bower
Surgical Aspects of Urinary Tract Trauma, Dr. W. Lamar Weems

FUTURE CALENDAR

October 6-10, 1969
Pediatric Intensive Course

October 7
Circuit Course, McComb

October 12-17
Electrocardiography Intensive Course

October 21
Circuit Course, Natchez
Circuit Course, Tupelo

October 22
Pulmonary Seminar

October 23
Circuit Course, Greenwood

October 30
Circuit Course, Greenwood

November 3-7
Gastrointestinal Disorders Intensive Course

November 6
Circuit Course, Greenwood

November 13
Current Concepts of Gynecologic Cancer

November 18
Circuit Course, Tupelo

December 4
Dermatology Seminar

January 6, 1970
Circuit Course, McComb

January 7
Circuit Course, Bilioxi

January 8
Circuit Course, Hattiesburg

January 19-23
Cancer Chemotherapy

January 27
Circuit Course, Columbus

February 4
Circuit Course, Biloxi

February 5
Circuit Course, Hattiesburg

February 9-13
Radiology Intensive Course

February 11
Seminar on Back Pain

February 17
Circuit Course, Natchez

February 24
Circuit Course, Columbus

March 2-6
Renal Disease Intensive Course

March 3
Circuit Course, Meridian

March 4
Circuit Course, Biloxi

March 12
Circuit Course, Hattiesburg

March 16-20
Cardiology Intensive Course
Stroke Intensive Course

April 1-3
Cardiovascular Seminar



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



POSTGRADUATE / Continued

April 7
CIRCUIT COURSE, MCCOMB
CIRCUIT COURSE, MERIDIAN

April 21
CIRCUIT COURSE, NATCHEZ

April 28
CIRCUIT COURSE, COLUMBUS

May 5
CIRCUIT COURSE, MERIDIAN

May 11-14
MISSISSIPPI STATE MEDICAL ASSOCIATION



PERSONALS

FORREST BRATLEY of Jackson is serving as special gifts physician for the Special Gift Crusade of the Hinds County Unit, American Cancer Socity.

HOLLIS BURROW of Greenville has been elected medical advisor to the Washington County chapter of the Red Cross. Officers will serve for one year.

G. A. BYNUM of Hattiesburg is currently serving as president of the Forrest County School Foundation.

GUY CAMPBELL and MYRA TYLER of Jackson recently attended the Koppa Memorial Pulmonary Disease Conference in Hunt, Texas.

EVERETT CRAWFORD of Tylertown has been elected president of the medical staff of the new Walthall County Hospital. Other officers are BEN CRAWFORD, vice president; JAMES MCLAIN, secretary; J. J. PITTMAN, chairman of the credentials committee; WALTER CRAWFORD, chairman of the accreditation committee; and J. O. WOOD, radiologist.

LEWIS CROUCH, JAMES CAVETT, RAYMOND MARTIN, ROSS BASS, GEORGE PURVIS and JIM HENDRICK, all of Jackson, recently played golf at the Port Royal Plantation's championship Barony Course at Hilton Head, S. C. They got pointers from golf pro Steve Huggins before teeing off.

WOODY DEAN DAVIS of Jackson is among 35 residents who began their specialty training at the University Hospital in Jackson July 1. Dr. Davis is studying ophthalmology.

THOMAS DOMINICK and JOHN EVANS of Vicksburg are members of the newly-formed Stop Smoking Committee. The committee has instituted a Smokers Dial and a Five-Day Plan to Stop Smoking conference was held in September.

GEDDES B. FLAGG of Gulfport will serve as chairman of the professional division of the Gulfport area in the forthcoming 1969 annual United Fund Campaign. Also serving as team captain is GEORGE VICKERY.

WILLIAM B. GIFFORD of Eupora has moved into the new Gifford Medical Clinic, located across the street from the Webster County Health Department.

GUY T. GILLESPIE, Regional Medical Program Cancer Coordinator, Jackson, attended a meeting of the Southeastern RMP Library Program in Atlanta in mid-August.

D. L. HARRISON, JR. of Calhoun City recently joined the medical staff at the Doctors Clinic in Grenada.

PAUL C. HORN of Greenville has relocated his office at 1315 East Union Street. Dr. Horn limits his practice to allergy.

FLOY J. MOORE of Jackson recently served as consultant on the use of audio-visual devices at the Raleigh Department of Health.

ROBERT L. PEEDE of Brandon announces the removal of his office to the Peede Medical Clinic at 100 Tamberlin Street.

THOMAS SHAW of Lucedale has been re-elected president of the Lucedale Country Club Board of Directors.

CLEVELAND B. SMITH of Columbia announces the opening of his office on the second floor of the Newsom Building for the practice of medicine and surgery.

JIM SMITH, a native of Meridian, began the practice of medicine in DeKalb Sept. 1. The University of Mississippi Medical School graduate will see patients in the nurses' home adjacent to the Kemper County Hospital.

JAMES P. SPELL of Jackson announces the removal of his offices to 500-D East Woodrow Wilson Blvd. in the University Plaza. Dr. Spell limits his practice to surgery and oncology.

C. O. Stanback of Columbus has moved his office to the Medical Art Center at 221 7th Street North.

Jack Stokes of Pontotoc has occupied his new clinic building located at the Highway 15 Bypass.

Michael Taleff of Meridian has associated with Dan H. Moore, Jr. and E. Lowry Moore at 1303 25th Avenue. They limit their practice to diseases and surgery of the eye.

Henry Thiede, UMC obstetrics-gynecology chairman, Jackson, presented two papers at an obstetric-pediatric postgraduate seminar in Fort Lauderdale in late August.

H. C. Watkins, Jr. of Quitman has returned to active practice in his office at the Watkins Memorial Hospital.

David B. Wilson of Jackson was honored during retreat ceremonies at Camp Shelby upon being promoted to the rank of brigadier general at the time of his retirement from the Mississippi National Guard. General Wilson had served as commanding officer of the 134th Surgical Field Hospital Unit, now the 213th Medical Battalion.

NEW MEMBERS

The following physicians have been elected to membership by their respective component Medical Societies in the Mississippi State Medical Association and the American Medical Association.

Patrick, Bernard Sutherland, Jackson. Born Booneville, Miss., Feb. 16, 1927; M.D., University of Mississippi School of Medicine, Jackson, 1950; interned Augustana Hospital, Chicago, Ill., one year; neurosurgery residency, St. Luke's Hospital and University of Illinois Research Center, Chicago, July 1, 1953-June 30, 1957; elected July 1, 1969 by Central Medical Society.

Rogers, Lee Hartwell, Tupelo. Born New Albany, Miss., Dec. 29, 1934; M.D. University of Mississippi School of Medicine, Jackson, 1960; interned John Gaston Hospital, Memphis, Tenn., one year; ophthalmology residency, Mass. Eye and Ear Infirmary, Boston, Sept. 23, 1963-March, 1964; City of Memphis Hospitals, Memphis, Tenn., July 1, 1964-June 30, 1967; elected June 10, 1969 by Northeast Mississippi Medical Society.

DEATHS

Knox, Isaac Cecil, Sr., Vicksburg. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1911; interned Vicksburg Charity Hospital, two years; Emeritus member of MSMA; member of MSMA Fifty Year Club; died Sept. 1, 1969, aged 82.

Sappington, Millard Cartwright, Vardaman. M.D., Columbia University College of Physicians and Surgeons, New York City, N. Y., 1953; interned Saginaw General Hospital, Saginaw, Michigan, one year; died Aug. 18, 1969, aged 50.

Award Offered for Surgery Paper

International Surgery, official journal of the International College of Surgeons, is announcing a cash award of $500.00 for the best scientific paper submitted by a surgical resident.

The award is being made available through a grant from Dr. Carroll J. Bellis. Dr. Bellis is a Fellow of the International College of Surgeons and practices general surgery in Long Beach, California.

Topics should stress the clinical aspects of surgical science. Scientific articles being entered must be original and must not have appeared elsewhere in print. Articles must be typewritten, double-spaced, and submitted in duplicate.

Bibliographies should be presented alphabetically, cover all references cited in manuscript and contain the following information: names and initials of all authors; full title of article or book; name of book's publisher; city and year published; name of periodical; volume number, page and year of publication.

All illustrations should have the following on the back: author's name, figure number, and the top clearly indicated. Captions must accompany illustrations and the approximate position in the text for the illustrations should be indicated. Slides are not acceptable. Captions for photomicrographs should give magnification and stain.

Deadline for entries is November 30, 1969. Articles should be sent to: Surgical Resident Award Program, International Surgery, 1516 N. Lake Shore Drive, Chicago, Illinois 60610.



In Gastritis

Also available as Estomul Tablets:

Each swallow tablet contains: orphenadrine hydrochloride, 25 mg.; bismuth aluminate, 25 mg.; magnesium oxide, 45 mg.; aluminum hydroxide-magnesium carbonate (as co-precipitate), 500 mg.

Indications: Peptic ulcer: duodenal, marginal, gastric, esophageal; gastroesophageal reflux; esophagitis (without stricture); irritable bowel syndrome; hyperacidity and dyspepsia; congenital shortening of esophagus with esophagitis; heartburn; spasm of the cardiac end of esophagus; gastritis; symptomatic hiatus hernia; alcoholic gastritis; functional pylorospasm.

Contraindications: Because of the anticholinergic action of orphenadrine, Estomul should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcers, prostatic hypertrophy or obstruction at the bladder neck, achalasia (megaesophagus), and myasthenia gravis.

Precautions: Doses in excess of six tablets or six tablespoons of liquid daily may produce minor side actions such as dryness of the mouth or blurred vision.

Warning: Use of any drug in pregnancy, lactation or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother and child. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Side Effects: Possible side actions include: tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, an elderly patient may experience some degree of mental confusion.

Dosage: For adults: One or two tablespoons of liquid or one or two swallow tablets three times daily; depending on severity.

Availability: On Rx only. 12 oz. bottles of liquid and bottles of 100 swallow tablets.

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antacid
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Each tablespoon (15 cc.) contains:
orphenadrine HCl, 25 mg.;
bismuth aluminate, 50 mg.;
aluminum hydroxide—magnesium carbonate
(as co-precipitate), 918 mg.

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Press, Government Overplay Medicare Fraud as State Physician Is Convicted

The Social Security Administration said that 219 cases of suspected fraud under Medicare are being investigated in the seven southeastern states. Information indicated that the irregularities involved both recipients and providers.

In Mississippi, a federal district court found Dr. John W. Conway, III, of Cleveland and formerly of Lucedale guilty of fraud under Medicare, sentencing him to three years probation and fining him $1,000.

Of the 219 cases in the southeast, SSA officials said that 144 are in Florida. There are 10 in Alabama, 15 in Georgia, 15 in Mississippi, nine in North Carolina, six in South Carolina, and 20 in Tennessee.

The SSA statement, reported by Associated Press, referred to padded charges, padded bills, forged checks, misrepresentation of goods by medical suppliers, and misrepresentation by physicians. About half of the cases involve bills for goods or services never actually provided, SSA said.

U. S. District Judge Orma Smith, sitting at Oxford, found Dr. Conway guilty of conspiracy to defraud the United States by making false statements and false representations to an agent of the Social Security Administration. Dr. Conway entered a plea of *nolo contendere* or no contest to the charges.

Dr. Conway, reported to be at Carnegie, Pa., was charged by U. S. District Attorney, H. M. Ray with irregularities in 34 Medicare transactions involving $5,192, the report said. The money has been recovered by the Mississippi Part 1-B carrier, the Travelers Insurance Co. The alleged fraud took place during 1965-67.

Dr. Conway, with a record of legal and licensure difficulties over the past few years, was not a member of the state medical association or of the American Medical Association. His was the first conviction of fraud under Medicare since the program was enacted in 1965.

Robert P. Bynum of Atlanta, regional Social Security commissioner, said that nationwide, 12 additional cases have been turned over to the Department of Justice by the Social Security Administration for prosecution.

Bynum also said that occurrence of fraud under Medicare has been very low. He pointed out that in four years, more than 200,000 physicians have rendered millions of services to 19.3 million beneficiaries.

A current editorial in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION deplored fraud under Medicare or any other health service program but said that "incidence and monetary loss in the program is less than employees of American business and industry take in company postage stamps."

The editorial called the program almost "simon pure" on a statistical measure based on Social Security Administration announcements of irregularities. The dramatic nature of fraud under the program was, however, recognized, as was the tendency of mass news media to dramatize every case brought to light.

"Assuming Florida with its relatively high incidence of cases in comparison with other southeastern states to be an anomaly," the editorial said, "then an extrapolation would indicate less than a thousand cases nationwide under investigation."

The editorial also deplored the wrongful "rub-off guilt" on the almost total number of physicians, hospitals, extended care facilities, and others providing services under Medicare. The editorial called for intensified effort in utilization review as a first step in ferreting out "any obviously infrequent irregularity" in the program.

In the Conway case, the *Delta Democrat Times* of Greenville reported that "34 additional counts charging him (Dr. Conway) with separate violations of the act were dropped when Oxford attorney Joel Blass told Judge Smith that Conway had made a 'new start' in Pennsylvania."

The newspaper also reported that "Blass said Conway had a history of amphetamine addiction and emotional disturbances for which he had received treatment at the state mental hospital at Whitfield and in Mobile from a private physician."

No announcement is made by the Social Security Administration to the public in instances of investigation of possible irregularities nor of referrals to the Department of Justice with recommendation for prosecution.

Federal grand jury indictments are, however, in the public domain. No estimates are available as to how many, if any, of the ongoing investigations in the southeast will be referred for prosecution.

Building Addition Remains on Schedule

Despite adverse weather and some supply problems, the association's building addition remains on schedule as the general contractor, Priester Construction Co., reports 35 per cent completion.

Dr. Mal S. Riddell, Jr., of Winona, building committee chairman, said that "the program continues on schedule, and there is no reason to believe that the contractor will not meet his commitment of 180 days with ease." He said that the architect, W. R. Bob Henry, A.I.A., of Jackson, concurred in the estimate.

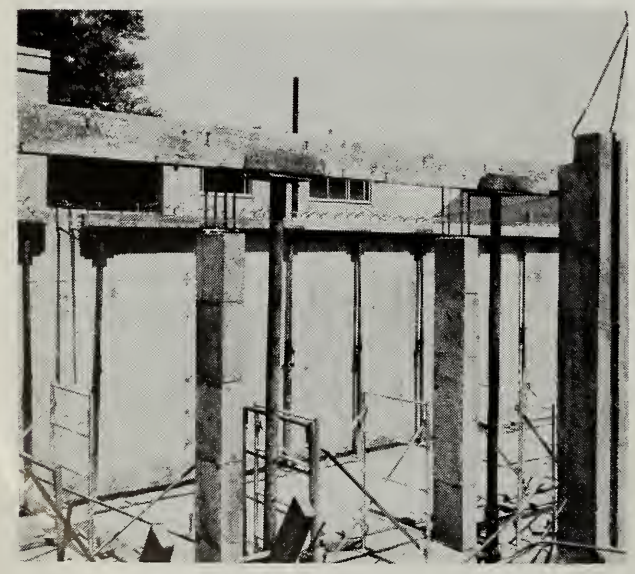
Dr. Riddell said that foundations and substructures have been completed and that steel erection has begun. The framing is structural steel at the grade or upper level. The lower level of the addition is re-enforced concrete over which masonry will be laid.

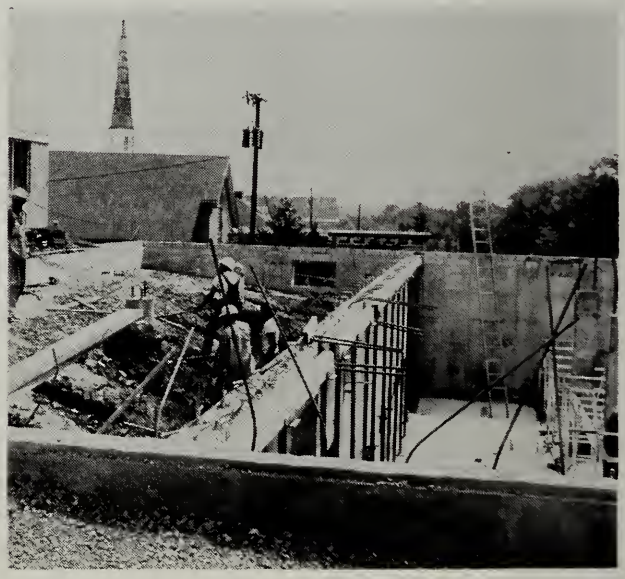
Electricians and plumbers have roughed in conduits and soil pipe at the lower level, permitting completion of the substructure flooring. Work has also been completed on joining the foundation of the main or original building, Dr. Riddell said. The steel framing will also figure into the joining of the addition to the main structure.

Working with Dr. Riddell on the building committee are Drs. J. T. Davis of Corinth and William O. Barnett of Jackson. The committee regularly reports to the Board of Trustees, as it did at the September meeting.

The contract calls for 180 calendar days for construction of the addition. Spokesmen said that the addition should be occupied by early January 1970. Recently, the committee has worked on needed furnishings for the addition.

The construction is under the supervision of the Board of Trustees as required by actions of the House of Delegates.





Near-completed substructure for the association's building addition shows, left, interior walls and supporting columns just before suspended floor was formed. Right, workmen prepare for floor forms as last step in lower level construction.

Hamrick Is New MSBH President

Dr. D. W. Hamrick of Corinth has assumed the presidency of the Mississippi State Board of Health, having been elected for the 3-year term at the regular June meeting of the Board.



Dr. Hamrick

The eye, ear, nose, and throat specialist, who has served as vice president of the Board since 1966, succeeds Dr. Joseph G. McKinnon as president of the 11-member Board.

Dr. Hamrick was appointed to the Board by Governor Ross Barnett in 1962. He was reappointed in 1968 by Governor John Bell Williams.

A graduate of Mississippi College with the A.B. degree, Dr. Hamrick received a Medical Certificate from the University of Mississippi and the M.D. degree from the University of Virginia Medical School. He is a Diplomate of the American Board of Otolaryngology and a member of the Mississippi State Medical Association, the American Medical Association, the Southern Railway Medical Society, and the American Academy of Ophthalmology and Otolaryngology.

MSMA and AMA Sponsor Lectures

The Mississippi State Medical Association, in cooperation with the AMA, is co-sponsoring a program of seminars and a lecture in nutrition in three universities in Mississippi during the 1969-70 academic year.

The AMA council on foods and nutrition initiated this program in the fall of 1964. It is being carried out on a regional basis with several distinguished lecturers participating.

The lectures are designed to stimulate undergraduate students to consider careers in the health sciences, as well as to inform the audience of recent developments in the field of nutrition.

A total of 55 lectures are being scheduled in an eleven-state area which includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Dr. Harold H. Sandstead, assistant professor of biochemistry and medicine, division of nutrition at Vanderbilt University, will speak on "The Role of Zinc in Human and Animal Nutrition" at Mississippi State University on Nov. 5 and at Mississippi State College for Women on Nov. 6.

Dr. John A. Owen, associate professor, department of internal medicine, the University of Virginia School of Medicine at Charlottesville, will speak on "Obesity: The Nutritional Paradox of America" at the University of Southern Mississippi on Oct. 29.

Dr. Sandstead obtained his M.D. degree at the Vanderbilt University School of Medicine. In 1967, he was a consultant in the Nutrition Section of the Office of International Research, Public Health Service.

Dr. Sandstead is a member of the American Institute of Nutrition, the Southern Society for Clinical Investigation, the American Federation for Clinical Research, and the American College of Physicians.

He has written approximately 28 articles pertaining to his major fields of interest, clinical nutrition and trace minerals.

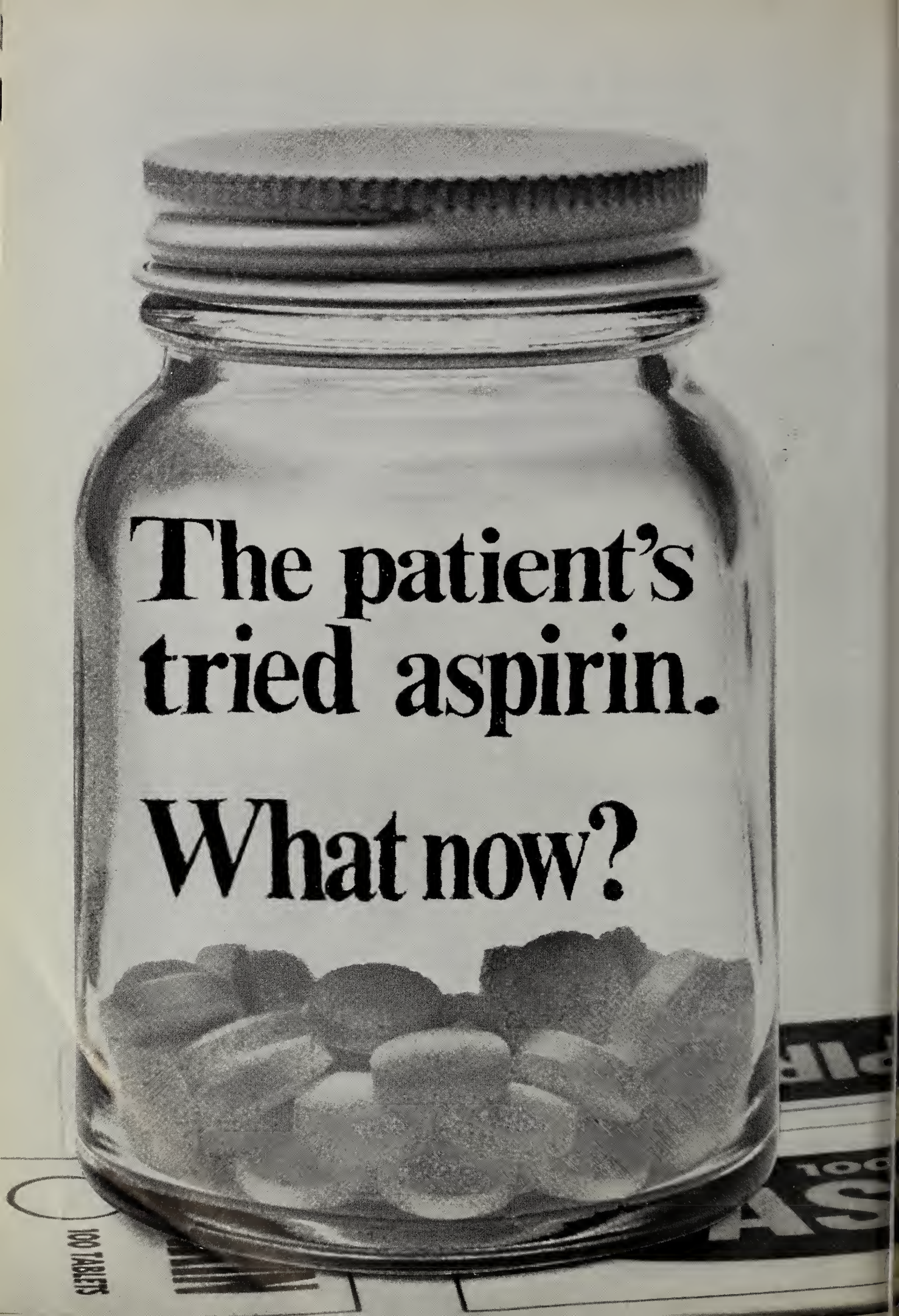
Dr. Owen received his M.D. degree from the University of Virginia School of Medicine in Charlottesville. He has written approximately 45 papers based on his research interests which include diabetes and obesity.

Rescue Workers Sharpen Skills

Rescue personnel from across the state are sharpening their emergency treatment skills through courses offered at the University Medical Center this fall.

Open to ambulance attendants, firemen, policemen and other nonmedical emergency workers, the training programs are part of Project CARE, funded by a grant from the National Highway Safety Bureau to the Mississippi State University Industrial Research Station. UMC associate professor of surgery Dr. William A. Neely is course coordinator.

Six of the three-day sessions are planned through October. Instruction will include training in such techniques as cardiopulmonary resuscitation and emergency management of electrical shock.


The patient's
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Book Reviews

Practical Psychiatry for the Internist. By Douglas Goldman, M.D. and George A. Ulett, M.D., Ph.D. 156 pages. St. Louis: The C. V. Mosby Co, 1968. $9.85.

Every internist has to be at least part amateur psychiatrist. So it was with considerable interest that I started to read *Practical Psychiatry for the Internist.* Right off, I encountered a curious bit of schizophrenia on the part of the authors. Despite their title, they say in the preface that the book is directed to all practitioners who are not psychiatrists. A title indicating that might have produced a wider sale among physicians other than internists. And certainly this book might profitably be read by any physician, whatever his specialty.

I have one other *caveat.* A good part of this book is tough reading, and unnecessarily so. Drs. Goldman and Ulett promise at the outset to avoid psychiatric jargon and mostly they do. But often they substitute a prose style that's so prolix and turgid that it's a burden to read. They seem enamoured of extra-long sentences with many modifying clauses and phrases. The section on human biology is particularly afflicted with this sort of writing. For instance on page 11 the sentence is: "For some women surcease from a pervasive and intense fear of repeated pregnancies represents a source of relief which may lead to a more relaxed and gratifying sexual adaptation." Why not just say: "Relief from an intense fear of pregnancy may lead to a more satisfactory sexual life"?

This is a sound book, if an internist is qualified to evaluate a book on psychiatry. The authors seem to be immanently sensible men, experienced in dealing with emotional illness, and aware of the limitations as well as the achievements of their specialty. Happily, they don't waste a lot of space on doubtful etiological theories. Nor do they throw in a lot of Freudian dogma. Of necessity they use some common psychiatric terms, but these will be generally familiar to the non-psychiatrist if only from reading Ann Landers.

All of us who treat sick people are involved with their emotional problems whether we want to be or not. Emotional disturbance is part and parcel of the practice of medicine. For those of us who have had some interest in this aspect of practice, and who have done even a modest amount of reading, and who have observed the reactions of our patients, there is not a lot of new information in this book. But it is an excellent summary of the subject and contains all of the basic information necessary to approach the management of psychiatric problems at the level of the non-psychiatrist.

The section on drug therapy, or psychopharmacology, as the authors call it, is particularly good. I was personally intrigued by the chapter on hypnosis since this was something I knew almost nothing about.

I recommend this book to any non-psychiatrist in medical practice (even if he's not an internist), and to Drs. Goldman and Ulett I recommend the book *Scientific Writing*[1] and earnestly hope they'll study it before writing their next book.

ROBERT RAY MCGEE, M.D.

REFERENCE

1. King, L. S., and Roland, C. G.: Scientific Writing, Chicago. American Medical Association, 1968.

Questions and Answers on Contact Lens Practice. By Jack Hartstein, BS, OD, MD. 199 pages with illustrations. St. Louis: The C. V. Mosby Co., 1968. $10.75.

Dr. Hartstein points out that the optical principles of contact lenses have been understood for over 150 years; that therapeutic lenses have been applied sporadically for almost 75 years; but only in the last 20 years has relative success been obtained. The author's experience in this field covers approximately this last 20 year period, a score of years marked by many areas of disagreement but an overall and progressive improvement in quality.

The question and answer format sounds forbidding, but Dr. Hartstein has presented his material in a most engaging manner. Much of the

information is actually abstracted from other authorities' work. This has been most generously acknowledged in the preface.

Dr. Hartstein's personal preference for patient selection, initial fitting technique, and problem lens modification are highly informative.

It should be pointed out that Dr. Hartstein's methods are those of a successful expert but may differ in some areas from those of other experts. Contact lens soaking, lens size, fitting with or flatter than K are all still open for debate.

The step-by-step approach of the author, nevertheless, offers the inexperienced practitioner excellent guidelines for developing his own technique and experience.

The printing, binding and quality of illustrations of the book are excellent.

This book is highly recommended for ophthalmology residents and practicing ophthalmologists interested in contact lens work.

JOHN J. WHITE, M.D.

Drug Companies Send Supplies

Nearly 10,000 packages of SMA Ready-to-Feed infant formula were loaded at Wyeth Laboratories' warehouses in Atlanta, Ga., and Memphis, Tenn., for shipment by airplane and trailer to Jackson, Miss., in the aftermath of Hurricane Camille.



Wyeth employees loaded nearly 10,000 cases of SMA infant formula for babies in the hurricane area.

Wyeth, pharmaceutical manufacturer headquartered in Radnor, Pa., supplied the pre-mixed, pre-sterilized formula on the request of physicians serving on a disaster relief committee in Jackson.

Pfizer Drug Company of New York City contributed $33,000 worth of antibiotics to be used for the victims of the hurricane.

Numerous other drug companies made varying contributions to the relief fund.

Tate County Opens Health Department

The dedication of a new $73,000 health center for the Tate County Health Department took place September 12.

The attractive colonial structure, located in Senatobia, is the first facility designed and constructed for public health use that the local health department has had in its 29 years of existence.

With the construction of this building, Dr. Hugh B. Cottrell, State Health Officer, says that Tate County has become one of the 68 counties in Mississippi in which the health department is housed in its own modern building.

Since its organization for full-time health services, the Tate County Health Department has been headquartered in four different buildings.

Its first home was an old red two-story schoolhouse on Highway 51 in Senatobia, long ago demolished. From 1948 to 1961, the health department was located in the County Building. For the past eight years, along with the County Welfare Department, it has had floor space in the Powell Clinic Building.

"The new health center—a wood frame and brick veneer structure with 2,625 square feet of floor space—provides the health department long-needed modern facilities," said Dr. Steven L. Moore, Director of Local Health Services for the State Board of Health, who is currently serving as acting health officer for Tate County.

The waiting room, which doubles as an assembly room, has a built-in screen and a new 16 mm projector on a movable stand for use in health education programs.

Adjacent to the waiting room is a playroom alcove where children can play while their mothers obtain services.

One of the special features of the health center is an immunization room, designed to facilitate the movement of people in and out of the clinic

when securing vaccinations. There are also two examination rooms.

The newness of the building is matched by the furnishings and the equipment—everything is new and up-to-date, including an x-ray machine.

The cost of equipment was included in the construction cost, two-thirds of which was contributed by the federal government through the Hill-Burton Act.

The building site and the other third of construction cost were provided by the Tate County Board of Supervisors.

The Tate County Health Department was organized for full-time services January 1, 1940, becoming the forty-fifth in the state.

Spearheading the movement was the late Dr. W. D. Smith, one of the leading local physicians.

Dr. Chester Farmer, today a well-known dermatologist in Laurel, Mississippi, was Tate County's first county health director. During his service of 17 months, he instituted a basic program to attack the current public health problems.

In the succeeding years eight health officers have served in Tate County, with an average tenure of about three years.

However, the long-time tenure of other staff members has given continuity to the health department program.

Mrs. Christine B. Floyd has been secretary since 1942. The sanitarian, Herbert K. Moore, joined the staff in 1949, when Tate and DeSoto Counties formed a health district. Mrs. Mary W. Newton has served as public health nurse since 1950.

UMC Team Surveys Appalachia Area

A University Medical Center team this summer surveyed the health care picture in Mississippi's 20 Appalachian counties.

Part of a cooperative project involving the Medical Center Department of Preventive Medicine, the Division of Comprehensive Health Planning and the Division of Appalachian Development in the Governor's Office of Federal State Programs, the inventory was aimed at finding out both the medical needs and resources of the area.

Edwin Bridgforth, UMC associate professor of preventive medicine and director of the medical student team, said survey results will serve as basis for applying for outside funds to support any needed programs for health care improvement in the 20 counties.

MSS States Compliance Policy

The Mississippi State Sanatorium at Sanatorium, Miss. has supplied MSMA with a copy of the hospital policy in compliance with the Civil Rights legislation of 1964.

Dr. Clyde A. Watkins, Superintendent, made the following statement: "It is the policy of the Mississippi State Sanatorium to admit and treat all patients without regard to race, creed, or color. All facilities of the hospital are available to all patients and visitors without discrimination in any regard. Courtesy titles are used by all employees with regard to every one."

Hurricane Losses Are Deductible

As a result of the President's declaration, certain fiscal year physician taxpayers may deduct their losses from Hurricane Camille which occurred on August 17 and 18, 1969, on their current fiscal year income tax returns.

As of now, this ruling affects taxpayers in the following 24 counties: Amite, Copiah, Covington, Forrest, George, Green, Hancock, Harrison, Jackson, Jefferson Davis, Lamar, Lawrence, Lincoln, Marion, Pearl River, Perry, Pike, Rankin, Simpson, Smith, Stone, Walthall, Wayne, and Wilkinson.

Hurricane Camille losses may be deducted on current fiscal year returns when the disaster occurs after the end of the tax year, but before the due date for the return.

Qualifying fiscal year taxpayers who have already filed their returns may claim their losses by filing an amended return on Form 1040X or Claim Form 843, within three months from the due date of their return.

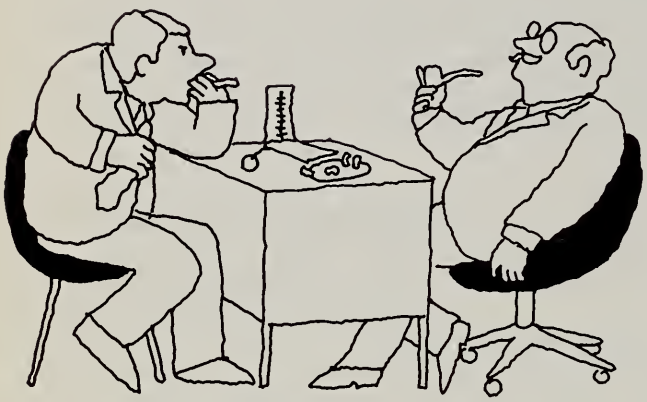
Since Hurricane Camille came after April 15, calendar year taxpayers cannot deduct their losses on 1968 returns. However, their losses can be deducted when returns for 1969 are filed.

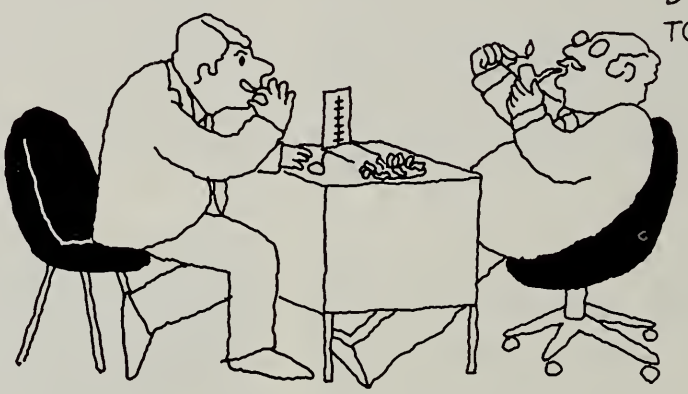
Non-business casualty loss deductions are limited to the amount over $100 for each casualty.

Individual physicians and business offices suffering extensive casualty losses will want to take these losses into account in satisfying their September installment of estimated tax.

Publication 547, "Tax Information on Disasters, Casualty Losses and Thefts," describes procedures for claiming casualty losses.

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rticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

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Phone Hook-Up Begun for Ala. Physicians

"This is a unique service—the only one of its kind in the country." That's the description Dr. Thomas W. Sheehy, professor of medicine, Medical College of Alabama and chief of medicine, Veterans Administration Hospital, applies to MIST. MIST is the code name of "Medical Information Service via Telephone," a new program sponsored by the Medical College and operated by the Alabama Regional Medical Program as a free service to state physicians.

The MIST telephone number, 1-800-292-6597, may be used by any doctor in Alabama to receive information needed for patient care. "It brings a medical service right into the physician's office. Nowhere else can a doctor call a medical center free of charge and receive personal answers to his questions from some of the most highly qualified specialists in the nation," Dr. Sheehy explained.

Dr. Clifton K. Meador, dean of the Medical College, first announced his idea for a physician's telephone information service in 1968. This year, organization and planning for the service began and, on July 1, 1969, the telephone lines were opened. According to an evaluative questionnaire issued under the program, many physicians in Alabama are already utilizing the service, and their favorable response to MIST is unanimous.

MIST is in operation twenty-four hours daily, seven days a week. Physicians receive immediate attention to their questions, including medical problems which occur on weekdays and emergency situations which arise on weekends.

All telephone conversations are tape-recorded. "We plan to take these recordings of the doctors and evaluate them, to determine the effectiveness of our program and what directions it might take in the future," noted Dr. Sheehy, who is director of MIST.

"Already the program has, by natural demand, increased in scope. It now includes General Surgery, the Department of Medicine, the Radiology Department for Oncology, Gynecology, Pediatrics, and Hospital Administration. In each, a faculty member is scheduled on-call at all times for answering MIST questions. When a practitioner has a problem on his hands and desires a colleague's opinion he can pick up the phone and get direct contact with a specialist in a given area.

"It is interesting to note that one-fourth of the calls so far were related to the treatment of cancer and nearly one-fourth to diagnosis and treatment of heart disease and stroke," said Dr. Sheehy.

Discussing the advantages of the MIST system, Dr. Sheehy continued, "MIST brings the Medical College faculty in close contact with the practicing physician in Alabama. This is mutually advantageous. When a faculty member knows what problems the physician faces in his office, he improves his pool of knowledge for classroom and laboratory instruction. In addition, this is a form of direct support for medical practitioners, a form of on-the-spot continuing education. MIST is also designed to assist in patient care in Alabama and to encourage faculty members to stay abreast of their specialties. It will help us in planning realistic continuing medical education programs."

The Medical College sponsors the service, underwriting its cost while application for Alabama Regional Medical Program financing is under consideration. The Regional Medical Program operates the service for the Medical College, with coordinator Mrs. Jerry C. Collier. The Medical Center Library also provides services for MIST, with responsibilities for dispatching free research and background information requested by physicians.

Plastic Society Has Med Review Board

The nation's plastics industry now offers an informal clearing house for technical data for physicians wishing to obtain information about a particular medical application of plastics.

A Medical Review Board, comprised of representatives of 28 companies in the plastics industry, has been established by The Society of the Plastics Industry, Inc.

Physicians who wish to have inquiries on plastics answered by the Medical Review Board are requested to submit fully detailed questions so that members of the Board will be able to provide comprehensive answers.

Questions on all areas of plastics in medicine are welcomed, including the various uses of prosthetics and implants as well as applications involving disposable plastics.

Inquiries may be submitted to C. L. Condit, Senior Division Administrator, The Society of the Plastics Industry, Inc., 250 Park Avenue, New York, N. Y. 10017.

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CONTENTS

ORIGINAL PAPERS

Recent Concepts in the Dumping Syndrome **493** THEODORE DRAPANAS, M.D.

Clinical Experience with Low Molecular Weight Dextran in Acute Myocardial Infarction **499** PER H. LANGSJOEN, M.D.

Carcinoma of the Esophagus: A Case Report **503** RUSH E. NETTERVILLE, M.D.

SPECIAL ARTICLES

Radiologic Seminar LXXXIX: Radiographic Differentiation Between Renal Cyst and Neoplasm **505** JOHN Y. GIBSON, M.D.

EDITORIALS

The Care Delivery System: Remade in Whose Image? **509** National Insurance?

Will Nixon Abolish OEO Extravagance? **512** Help or Waste

The Price Tag on Liability Coverage **512** Up, Up, and Away!

A New Definition of Fetal Life **513** Legal Landmark

Yin and Yang: Villains of Disease **513** Herb Medicine

THIS MONTH

The President Speaking **508** Basis of Excellence

Medical Organization **521** Mississippi Postgraduate Institute in the Medical Sciences Opens at Medical Center

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Squibb Introduces New Cancer Agent

Teslac (Testolactone aqueous suspension), an entirely new compound intended for use as a chemotherapeutic agent in the palliative management of advanced or disseminated mammary cancer, has been introduced by E. R. Squibb & Sons, Inc.

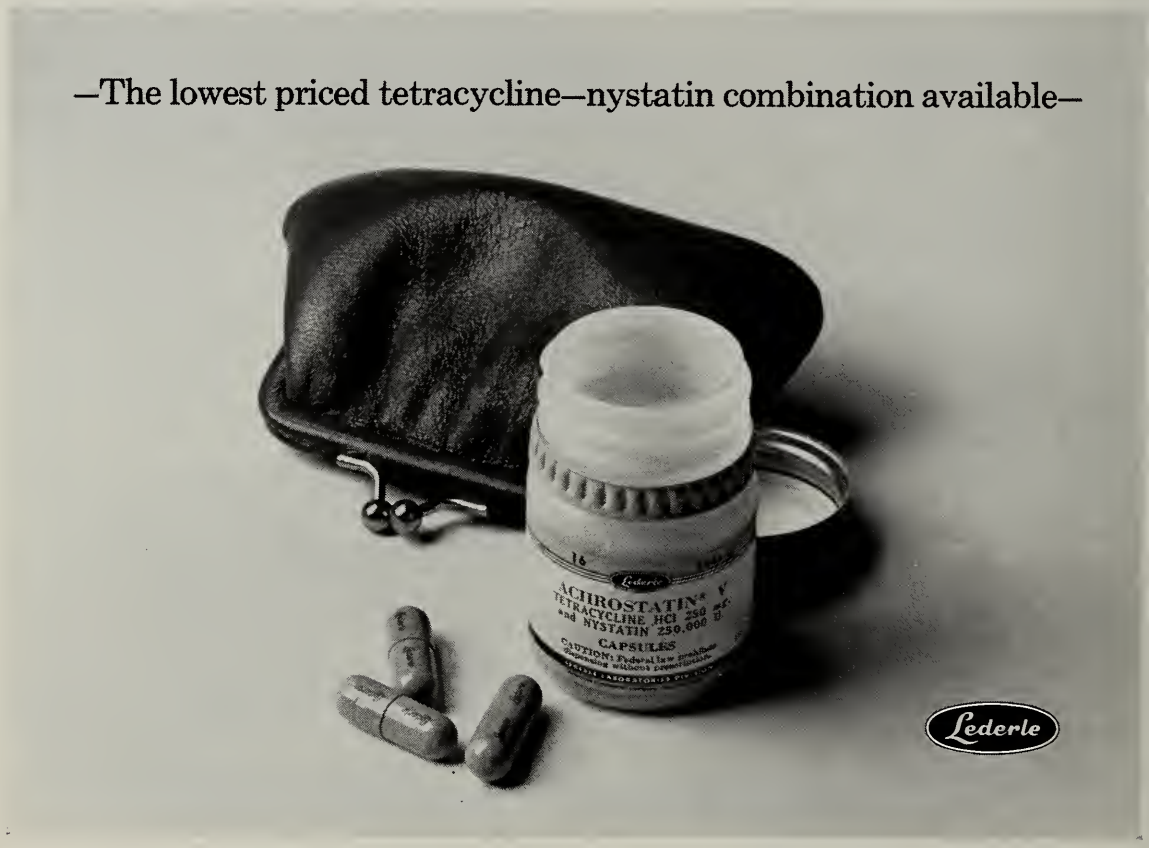
A lactone derivative of the androgenic hormone, testosterone, Teslac has been under clinical investigation for more than ten years. Its introduction represents a significant advance in cancer therapy for it achieves the elusive scientific goal of separating therapeutic action from side effects by being devoid of the major biological activity of a hormone—the masculinizing effect of testosterone—while retaining the desirable property—the antineoplastic action—of that androgen.

Effective in over 13 per cent of patients treated, Teslac is not intended to replace surgery or irradiation therapy in local or early disease. It is recommended in the palliative treatment of advanced or disseminated breast cancer in postmenopausal women when hormonal therapy is indicated. In premenopausal women with disseminated breast cancer, castration either by surgery or radiation is recommended prior to initiation of therapy with Teslac.

Experimental and clinical evidence indicate that Teslac, when used in recommended doses, has no biological activity other than that of causing an objective regression or arrest of advanced mammary carcinoma. Its advent is a significant step forward because for the first time, it permits the direction of an apparently nonhormonal anticancer agent to a special disease; it is not cytoxic and, therefore, lacks the hazards associated with the use of other antineoplastic agents, such as the antimetabolites and alkylating drugs. It is also free of estrogenic, uterotrophic, orogestational, glucocorticoid, gonadotrophic, antiprogestational, antiuterotrophic, antiestrogenic or cholesterol-altering activity; and does not complicate treatment with certain unwanted side effects typical of other androgenic compounds.

Teslac is available for intramuscular injection in vials of 5 cc.

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AABB Announces New Publication

The American Association of Blood Banks has published a 113-page, hard-cover *Manual of Blood Component Preparation,* a comprehensive summary of blood component methodology compiled during two years of AABB practical workshops given throughout the United States. The manual details the principles and technics of blood component preparation with comments on therapeutic indications for each of the components. Included are the technics of centrifugation and plasmapheresis, the preparation of leukocyte-poor blood, packed red blood cells, plasma and platelet components.

Each chapter details the equipment needed and and stresses the appropriate quality control measures. The technic for each component preparation is likewise given in easily followed, step-by-step fashion. Standards requirements are stated, sample labels illustrated, and suggestions for keeping records and nomograms for body surface area are included in each chapter.

The chapter on Red Blood Cells outlines the preparation of packed red blood cells from single-unit collections of blood, either in a plastic bag or in a glass bottle, and from blood collected in multiple bag units. The multiple methods available for preparation of leukocyte-poor blood, including inverted centrifugation, nylon filtration, dextran sedimentation and saline washing are detailed in the chapter on Leukocyte-Poor Blood. The chapter on Platelets gives the technic and quality control measures necessary to prepare platelet-rich plasma and platelet concentrates; and, the chapter on Plasma explains in detail the production and reconstitution of cryoprecipitate and discusses the preparation and use of single donor plasma, fresh frozen plasma and pooled plasma.

David T. Borucki, M.D., Scientific Director of the American Association of Blood Banks Component Therapy Workshop Program; L. Ruth Guy, Ph.D., Chairman of the Committee on Workshops and Miss Mary Beth Heustess, M.T. (ASCP)BB, Technical Director of the Workshop Program, compiled and edited the manual with significant contributions having been made by outstanding physicians and technologists in the field of immunohematology.

Copies of the book are available only through the Association's Central Office, at $5.00 each, payable in advance.

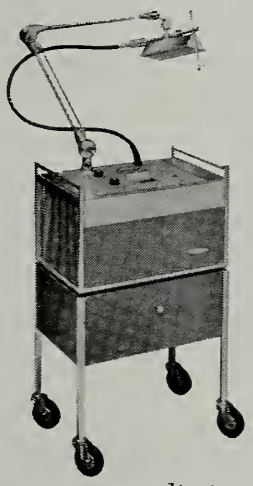
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

November 1969

Dear Doctor:

Dr. Alton B. Cobb of Jackson has assumed duties as director of the Medicaid Commission and is organizing program. Task is gargantuan, because plan must be prepared, funding secured, and mechanics for claims payment set up within close deadline of Jan. 1, 1970, cutoff date for old programs.

> Gov. Williams named a blue-ribbon list of public members to new commission. They are Earl Evans, Canton industrialist; Ed Kossman, Cleveland auto dealer and past president of national auto dealers association; and Charles B. Ryan, Jackson, president of MPI Industries.

California Supreme Court made landmark decision by becoming first high tribunal to rule on a state abortion statute. Ruling reversed conviction of M.D. under old 1850 law, stating that "a woman has a right to decide whether she wants children." Opinion is that California may have to liberalize new law on which court did not rule.

The price of Medicare goes up Jan. 1 for the second time, affecting both Part 1-B premiums and 1-A deductibles and co-pay provisions. Patients will pay $52 on admission to hospital instead of present $44, and daily co-pay jumps to $13 from $11 after 61st day. Rate goes to $26 per day after 90th day on reserve credit. Look for premium increase under 1-B to $4.50 or $5 per month.

Nine Mississippi M.D.'s were among 1,523 candidates inducted into Fellowship by American College of Surgeons at San Francisco. College reports that this was a record and that organization now has 30,000 members (Fellows) in 92 countries.

Department of Defense has announced that use of service serial numbers on CHAMPUS claims will be phased out. Instead, Social Security numbers will be used. For present, forms have places for both, but either number may now be used. Conversion will take time, but Social Security number is preferred. Claims identified either way will be processed.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Cyclamate Makers Hint 'Sugar Lobby' Influence

New York - Some spokesmen for the cyclamate industry have hinted that the "sugar lobby" may have exercised influence on the sweeping decision of HEW and FDA to outlaw the artificial sweeteners. All announcements coming from federal sources attribute decision to tentative findings of cancer caused in lab animals by massive doses of cyclamates. Entire affair has been cloudy with many pro and con reports. Decision has massive economic impact.

Dentists Have Good Antismoking Record

Chicago - The dental profession may have the best antismoking record among professional individuals, according to ADA and Public Health reports. A third of the nation's D.D.S.' have never smoked, over a third have stopped, and less than a third still smoke. A survey of dentists showed that seven out of 10 felt that they had a responsibility to set an example for patients by not smoking. Not surprisingly, survey also showed concern for oral cancer.

Consent Decree Is Issued In Optometry Suit

Jackson - The State Board of Health and State Department of Education have concurred in a consent decree, settling a suit filed by State Board of Optometry. Terms of settlement order full free choice between optometrist and M.D. ophthalmologist for patients entitled to services under state programs of eye care. Major program concerned is school health service.

Pediatricians Have Lowest Suicide Rate

Chicago - The American Academy of Pediatrics reports a study showing that pediatricians have the lowest suicide rate of any discipline of medicine, only 10 per 100,000, compared with 11 for the population of the nation. Studies were made by Chicago Medical School which also reported that "pediatricians get highest personal gratification from their work."

Seniors Reply On Private Insurance

New York - The Health Insurance Institute says that about as many persons over age 65 who had private health coverage before Medicare still carry it and pay premiums. Recent survey showed about 10.2 million seniors with private contracts to supplement Medicare. Industry is paying out just under $1 billion annually in claims. Practice will probably grow as more employers provide private coverage for the retired.

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Indications: Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders. Here, Norgesic demonstrated clinical superiority to APC as an analgesic.

Contraindications: Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy, obstructions at the bladder neck, myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child. USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders.

Adverse Reactions: Side effects of Norgesic are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, some degree of confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

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Antibiotic Fights Bone Disease

Mounting evidence of success in the treatment of osteomyelitis with Lincocin (lincomycin, Upjohn), an antibiotic first found effective against the serious bone infection in 1963, was reported by physicians at the annual meeting of the American Academy of General Practice.

A five-year compilation of 215 patients showed a record of healing or improvement in 187—or 87 per cent of the cases. Only 28 of the patients were classified as treatment "failures," and three of those had shown mild side effects. The summary of reports by 14 doctors was part of a scientific exhibit presented by Drs. Joseph E. Grady, Ph.D. and Howard H. Angell, M.D., medical investigators with The Upjohn Company, Kalamazoo, Michigan.

Researchers attribute the effectiveness of oral doses of Lincocin in the treatment of osteomyelitis primarily to its ability to reach and maintain high levels of concentration in bone—levels which exceed those of earlier antibiotics. This, plus its strong anti-staphylococcal activity is credited for the success achieved in such a high percentage of cases.

Pointing out that treatment of osteomyelitis is difficult under the best circumstances, Drs. Grady and Angell reported that when it becomes chronic "the organism most frequently encountered is a hardy penicillinase-producing staphylococcus." The failure of other antibiotics to overcome that infection "is most often due to lack of development of adequate bone concentrations of the antibiotic employed."

The bone-penetrating properties of lincomycin were emphasized in the exhibit which summarized the work of other investigators who had tested its effect on rats and in human teeth.

They showed that large oral doses of Lincocin produced peak concentrations of antibiotic activity in rat bone within 15 minutes. When given intramuscularly to a group of dental patients at intervals 20 hours before the extraction of teeth, similarly high concentrations were found in the alveolar bone.

Other advantages of Lincocin in the treatment of osteomyelitis cited by the Upjohn researchers were ease of administration, lack of cross-resistance, slow development of resistance and low toxicity.

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Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
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For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

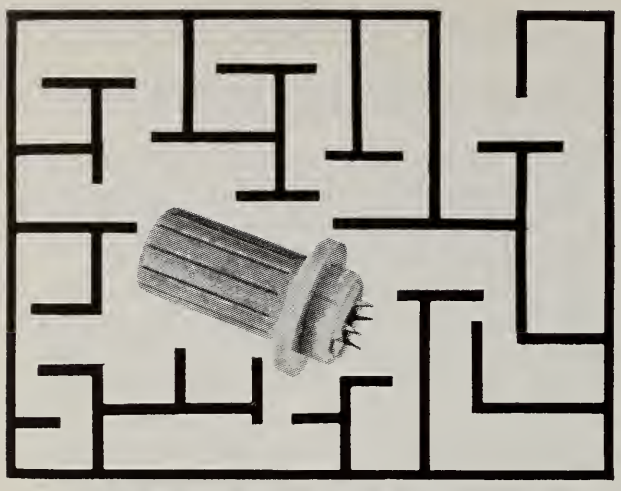
Preludin may be used to curb appetite in obesity associated with such conditions.

For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-evening suppression of appetite.

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A·H·ROBINS

Physicians Use Programmed Learning

Physicians from around the nation, gathering in Philadelphia for the annual meeting of the American Academy of General Practice, found a challenging opportunity to test and strengthen their medical knowledge in key clinical areas. The opportunity came in the form of 100 programmed learning machines, open free to the physicians throughout their meeting at Philadelphia's Civic Center.

Sponsored by Wyeth Laboratories, Radnor, Pa., pharmaceutical manufacturer, the educational programs offered the GP's a chance to brush up on the following areas:

—Treatment of thyroid disorders.
—Diabetes control.
—Liver function tests.
—Dermatology.

In addition, a new Wyeth program dealing with Office Gynecology was premiered at the AAGP meeting. This was authored by Alvin Goldfarb, M.D., associate professor of obstetrics-gynecology at Jefferson Medical College, Thomas Jefferson University, Philadelphia. Doctor Goldfarb was available at the Wyeth-sponsored exhibit at selected times throughout the meeting to answer questions from physicians taking the course he authored.

The five programs were presented by Wyeth in cooperation with the American Academy of General Practice. In February, 1969, a Board of Family Practice was created, and now requires that members pass a rigorous examination to become licensed in the Family Practice specialty. In addition, the GP's must complete 150 credit-hours of postgraduate study every three years to remain members of the Academy. The AAGP is the only medical organization in the world that has such an educational requirement for members.

Jack Rothstein, manager of medical promotion at Wyeth, stated, "Wyeth has made the programmed learning machines available at the Academy meeting in recognition of the heavy educational demands placed on member physicians. The programs are actual courses, and the AAGP gives one hour of postgraduate study credit for time the physician spends taking each of these programmed courses."

Mr. Rothstein also said Wyeth is making the five programs available upon request to state chapters of the Academy for their annual meetings.

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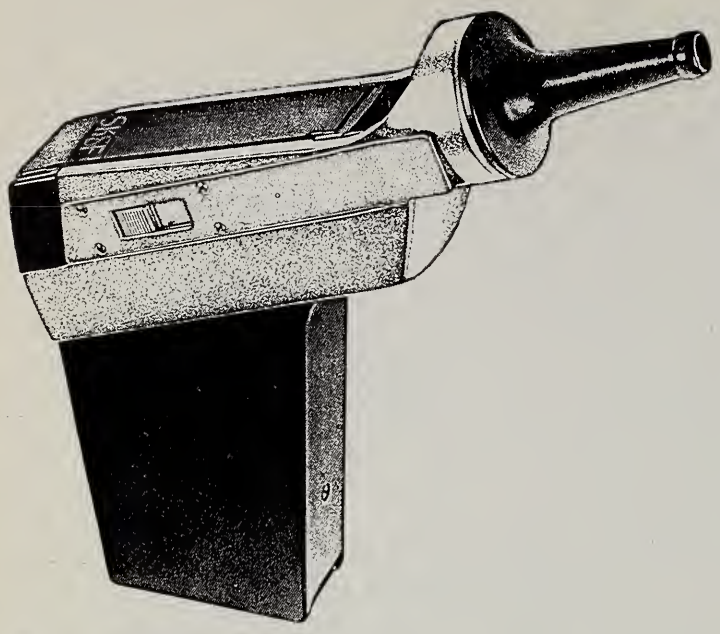


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the crisis is fleeting,
experiment risky,
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Univ. of Illinois Sponsors Speakers

The University of Illinois Medical Center has developed a speakers bureau to supply speakers on subjects related to the health sciences to organized groups in the state.

The speakers bureau is located on the campus near Chicago's west side and includes highly-qualified researchers, educators and practicing health science professionals.

Speakers must be given at least 30 days advance notice and the audience must contain 50 or more persons. Alternate speakers must be listed and financial arrangements, if any, made between the group and the speaker.

The University's Medical Center Campus includes the Colleges of Medicine, Dentistry, Pharmacy and Nursing, the Graduate College, University Hospitals and Clinics and the School of Associated Medical Sciences (a division of the College of Medicine that offers baccalaureate degrees in four allied health professions: medical art, medical record administration, medical technology and occupational therapy).

Included in this educational network is a vast amount of on-going research in all of the health sciences. Speakers are available to discuss an infinite variety of subjects from the common cold to organ transplants.

Merrell Develops High-Capacity Antacid

Delcid High-Capacity Antacid will be released to the medical profession in mid-October by The Wm. S. Merrell Company.

Delcid, a product of Merrell research, is a high acid-consuming product which is concentrated by a special process of ionic flocculation. On an equal-volume basis, Delcid neutralizes at least three times more hydrochloric acid than any of the three leading liquid antacids.

The dose of Delcid is a single teaspoonful, or only one-third the volume of conventional liquid antacids. Delcid is for patients who require frequent or long term administration of an antacid for treatment of peptic ulcer and gastric hyperacidity.

Delcid is available in an 8-oz. plastic bottle.

The first Medihaler was developed for the physician-inventor's own child.

The improved model you prescribe today is still made with the same painstaking devotion.

When your patient is in the grip of bronchospasm and reaches for his Medihaler, it must work. Not sometimes. Not most of the time. *Always.*

This is the ideal of perfection which has motivated the constant process of improvement of Riker's Medihaler.

Since its invention in 1956—when a Riker physician developed the Medihaler because of his determination to make better treatment available for his own asthmatic child—Riker has pioneered just about every significant forward step in bronchodilator aerosol therapy.

Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

Riker was first to formulate medication in a non-irritating, non-alcoholic vehicle.

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Add to these advantages a quality control system involving 168 physical measurements and chemical tests, plus not one but two test firings on every single unit leaving the plant, and you can readily see why there is no more dependable relief for bronchospasm than your prescription for Duo-Medihaler or Medihaler-Iso.

Please see next page for complete prescribing information.

Medihaler-Iso®
(isoproterenol sulfate)



Duo-Medihaler®
isoproterenol HCl (4mg./cc.)
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The Riker Representative in your area is: Dalton Johnson

SUMMARY OF PRESCRIBING INFORMATION

DUO-MEDIHALER®

(isoproterenol hydrochloride and phenylephrine bitartrate)

Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Northridge, Calif. 91324

U.S.P. Wants Essays on Drug Therapy

The United States Pharmacopeial Convention has invited full-time graduate and undergraduate students of accredited pharmacy and medical schools throughout the country to prepare papers on the topic, "The U.S.P. Role in Improving Drug Therapy."

The U.S.P. announced that two awards will be presented: one for the best paper submitted by a pharmacy student and one for the best paper submitted by a medical student. The winners will each receive an award of $250 and an expense-paid trip to the U.S.P.C. Sesquicentennial Meeting in Washington, D. C. in April 1970.

Each pharmacy and medical school is being asked to select the two best papers submitted by students attending that school. The papers selected by each school will then be submitted to the U.S.P.C. for final selection. Only papers forwarded by the schools will be considered. Papers will be judged primarily on originality, practicality of ideas, clarity and organization of any proposals, composition, and adequacy of documentation.

The U.S.P.C. contest is but one part of the preparations for the 1970 Sesquicentennial Meeting. It is anticipated that this meeting will result in establishment of new policy and guidance aimed at giving the U.S.P. a larger role in providing the pharmacist and physician with information on U.S.P. drugs and drug products.

Also in preparation for the 1970 meeting, the U.S.P. staff is planning several one-day "retreats" in selected areas around the country. These retreats will provide an opportunity for mutual in-depth exploration of the opportunities and problems for the U.S.P.C. and the organizations that constitute it.

Louisiana Society Holds Assembly

The Jefferson Parish Medical Society of Louisiana held its third annual Clinical Assembly Oct. 3-5 at the Broadwater Beach Hotel in Biloxi. Mississippi physicians were among those attending.

The scientific program this year included as guest speaker Dr. Robert B. Greenblatt, internationally known endocrinologist from the Medical College of Georgia.

In addition to the scientific sessions, there were golf tournaments, cocktail parties and a banquet at which Dr. Greenblatt spoke.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1969, Vol. X, No. 11

ORIGINAL PAPERS

Recent Concepts in the Dumping Syndrome

THEODORE DRAPANAS, M.D.
New Orleans, Louisiana

Although the dumping syndrome may be present in variable degrees in 5 to 30 per cent of patients undergoing gastric surgery, a number of other conditions may simulate this condition. The author discusses differential diagnosis and the etiology of the pathophysiologic changes occurring in this syndrome.

FOLLOWING THE ORIGINAL description in 1913 by Hertz of Guy's Hospital in London of the complex entity now called the "dumping syndrome," many reports have appeared in the literature expounding a large number of theories to explain the pathophysiology of this syndrome. Machella of the University of Pennslyvania in 1948 was the first to conclude that dumping was initiated by the rapid emptying of foodstuffs, particularly hyperosmolar materials, into the proximal intestine producing an intraluminal outpouring of fluid from the intestinal mucosa in response to the hypertonic stimulus. In a classic report in 1954, Roberts and Randall and their associates were able to measure accurately the blood volume alterations occurring from this marked fluid shift into the intestine, and they were able accurately to pinpoint a major physiologic cause of some of the symptoms which are commonly seen.[1]

These studies were the foundation for further investigations which have led not only to the better understanding of the etiology of the "dumping syndrome" but also to a rational method of treatment by diet, pharmacologic control and, in some few instances, remedial operative procedures.

From the Department of Surgery, Tulane University School of Medicine.
Read before the 101st Annual Session, Mississippi State Medical Association, Biloxi, May 13, 1969.

The basic common denominator in the production of the dumping syndrome is the rapid entry of an hyperosmolar meal into the proximal small intestine. This may occur whenever any surgical procedure bypasses the pylorus such as a gastroenterostomy; when the pylorus is rendered nonfunctional as in pyloroplasty; or when the pylorus is removed. Finally, the use of a proximal feeding jejunostomy in which hypertonic substances are introduced into the bowel is also attended with a degree of dumping. This latter method has been utilized as a technic for the study of dumping in the experimental animal.

SYMPTOMS

Generally three phases of the dumping syndrome can be recognized (Table 1).

Vasomotor Phase. This phase occurs early in the dumping syndrome usually during, or immediately following a meal. The primary symptom appears to be flushing with an unpleasant warmth, and this is usually accompanied by diaphoresis and severe anxiety. The patient may be conscious of his heart beat and tachycardia. He may also feel weak and exhibit dizziness.

Gastrointestinal Phase. This phase occurs immediately after the vasomotor phase within 15 minutes following a meal and may last up to 45 minutes. The patient may have abdominal cramps and may be nauseated. Vomiting may occasionally occur but this is not a prominent feature. An explosive diarrhea occasionally follows. Following the diarrhea the patient may feel drowsy and weak. Occasionally orthostatic hypotension may accompany this phase.

Late Phase. Few, if any, patients exhibit the late phase of the dumping syndrome. This phase is that of "rebound hypoglycemia" and is delayed until one to three hours following a meal. There may be extreme hunger, nervousness, and weakness. The symptoms are those of hypoglycemia. Blood sugar drawn at this time may show levels as low as 30 to 40 mg. per cent. Generally these symptoms can be controlled by the ingestion of simple sugars or fruit juice.

DIFFERENTIAL DIAGNOSIS

Although dumping may be present in variable degrees in 5 to 30 per cent of patients following gastric surgery, it must be emphasized that a number of other conditions exist which simulate dumping and which must be carefully ruled out.

TABLE 1

DUMPING SYNDROME

Early (9-20 minutes)
Flushing, unpleasant warmth
Profuse diaphoresis and anxiety
Profound weakness
Cardiac palpitations
Tachycardia and hypertension
Intermediate (15-45 minutes)
Abdominal cramps
Diarrhea
Nausea and vomiting
Drowsiness
Hypotension
Late (1-3 hrs)
Hypoglycemic episodes
Lethargy
Weakness

Afferent loop syndrome. This syndrome is seen most commonly after a Bilroth II type of gastrectomy, particularly when a long afferent loop has been fashioned. Adhesions, kinking, or torsion may lead to intermittent obstruction producing diffuse upper abdominal pain, nausea, and vomiting. At times, the vomiting may be explosive in character and contains bile. This has led some to describe this as the syndrome of "bilious vomiting." If undetected, this entity may lead to severe disability with malnutrition, cachexia, and weight loss. Not uncommonly diarrhea is also an accompanying feature. The latter may be due to bacterial overgrowth within the obstructed afferent loop leading to a bacterial gastroenteritis. A foul odor may also accompany the emesis.

The diagnosis can usually be suspected on the history but confirmation by barium studies is important. Occasionally a flat film of the abdomen will demonstrate a large, air-filled loop in the right upper quadrant. Following the ingestion of barium, residual amounts may be detected within the afferent loop for many hours even though the remaining barium has been completely emptied from the gastrointestinal tract. It must be emphasized, however, that in an occasional instance the afferent loop may be so tight as to prevent any barium entering it, and the typical radiographic appearance is not present.

Recurrent ulcer. In patients where the ulcer diathesis has not been controlled by the operative procedure previously performed, the appearance of symptoms relating to recurrent ulcer may be confused with those of the dumping syndrome. This is particularly true in patients who develop an element of obstruction resulting in feeling of fullness following meals, nausea, and emesis. Although careful x-rays might reveal the presence of a recurrent ulcer, it should be pointed out that a significant proportion of recurrent ulcers are not demonstrable by x-rays. This is true in approximately 50 per cent of marginal ulcers following a gastrojejunostomy and in approximately 30 per cent of duodenal ulcers following a gastroduodenostomy. Particularly if the patient has pain, effort should be made to rule out the possibility of a recurrent ulcer, including gastric analysis and study of gastric residual. The penetration of a recurrent ulcer into the colon producing a gastro-jejuno-colic fistula may be associated with severe weakness, weight loss and diarrhea following meals. The diarrhea in this instance is due to the highly contaminated colonic flora entering the upper gastrointestinal tract through the fistula and producing a bacterial enteritis. Such a fistula can usually best be demonstrated by means of a barium enema.

Chronic pancreatitis and pancreatic insufficiency. Symptoms of dumping may also be mimicked by the development of chronic pancreatitis in patients with previous gastric surgery. Such a possibility should always be considered in patients with a long history of alcoholism, particularly if the symptoms appear to be aggravated by alcohol intake. Occasionally, injury to the accessory pancreatic duct (duct of Santorini) may occur during removal of a penetrating duodenal ulcer producing obstruction of the accessory duct within the head of the pancreas and leading to recurrent bouts of pancreatitis. These bouts are often precipitated by a heavy meal producing pain, abdominal discomfort, and nausea. The development of chronic pancreatic insufficiency may also produce a pattern of malabsorption and diarrhea with foul smelling, frothy stools containing undigested material. In such circumstances the careful evaluation of the intestinal tract by x-ray and subsequent studies with tagged tracer substances such as d-xylose, fatty acids will confirm the malabsorptive pattern. Pancreatic enzyme replacement therapy may be helpful in such patients.

Hiatus hernia. An undetected hiatus hernia following gastric surgery may similarly produce symptoms of abdominal distress, fullness, and regurgitation. Such symptoms may be confused with early dumping, particularly if a careful history is not taken. Careful fluoroscopic observation during barium ingestion should confirm the presence of esophageal reflux and this may be subsequently confirmed by esophagoscopy. In the absence of achlorhydria following a major gastric resection, reflux of alkaline intestinal contents resulting in alkaline esophagitis may produce a similar picture.

Post-vagotomy effects. The watery diarrhea which occasionally accompanies truncal vagotomy (10-20 per cent of patients) should not be confused with the dumping syndrome. In such patients, the diarrhea is not accompanied by flushing, weakness or other vasomotor phenomena. Usually the diarrhea is a self-limiting process and with adequate control of diet, most patients become asymptomatic within a few months following the vagotomy. The etiology of the post-vagotomy diarrhea is unknown but changes in mesenteric blood flow or regenerative ability of the mucosal villi have been postulated as etiologic factors.

In 1961, Johnson and Jesseph[2] introduced the concept that some of the features of early postprandial dumping could be attributed to vasoactive materials released from the proximal small intestine in response to hyperosmolar stimulation. These vasomotor alterations have been documented by a number of investigators including the authors.[3] In Table 2 are shown the changes in a number of vascular beds, including cardiac output, which we have documented in the experimental animal and also in patients.[4] Following the ingestion of an hyperosmolar meal there was an immediate increase in pulse rate, peripheral blood flow and mesenteric blood flow. These changes were measured by a square wave electromagnetic flow meter and/or plethysmogram, or both. However, there was a simultaneous fall in cardiac output, cerebral blood flow, renal blood flow and coronary blood flow during this phase. These changes would indicate that a major redistribution of blood flow to the periphery occurs away from vital organs, namely the brain, kidney and heart, in the presence of a diminution in cardiac output. These changes are the reverse of what one would expect to find if the vasomotor effects were due to loss of vascular volume into the intestine alone.

TABLE 2
VASOMOTOR CHANGES IN DUMPING SYNDROME

Pulse Rate	Increased
Peripheral blood flow	Increased
Mesenteric blood flow	Increased
Cardiac output	Decreased
Cerebral blood flow	Decreased
Renal blood flow	Decreased
Coronary blood flow	Decreased

At the present time it is known that a number of vasoactive substances are implicated in the vasomotor reactions occurring during the dumping syndrome.[4–7] Notable among these are serotonin (5-hydroxytryptamine) and bradykinin. In previously reported studies, using a standard dumping model in the experimental animal, we have demonstrated that the infusion of hypertonic glucose into the proximal small intestine effects a rise in plasma protease activity with activation of free circulating bradykinin and a depletion of bradykinin precursor, bradykininogen.[6] These observations strongly confirm the initial suggestions of Zeitlin and Smith[8] who contended that the vasomotor reactions in dumping could not be adequately and consistently explained by serotonin action alone, even though the gastrointestinal manifestations may be.

Although it has been known for a long time that diminished absorption of foodstuffs, notably fats, occurs following gastric surgery, the exact mechanism for this diminished fat absorption had

not been previously well defined. It had been presumed that this was related to intestinal hurry resulting in a limited exposure of the foodstuffs to the digestive effects of the pancreatic and intestinal enzymes. Based on additional studies of pancreatic exocrine function during experimentally induced dumping, we now feel that a significant factor in the diminished fat absorption in these patients is due to the direct effect of these vasoactive hormones upon pancreatic exocrine secretion. Following the induction of dumping in dogs by the introduction of hypertonic glucose into the proximal jejunum, a significant and profound fall of pancreatic exocrine secretion as measured through a pancreatic fistula was present for periods varying from one to two hours as compared to control studies in which iso-osmolar solutions were injected (Figure 1.) Similar alterations in pancreatic exocrine function were produced by the intravenous injections of small doses of serotonin in these animals, thereby giving further support for a humoral mechanism in the etiology of pancreatic insufficiency and the diarrhea accompanying dumping. In our experience, the use of pancreatic supplements has controlled some of the diarrhea associated with dumping, thereby giving further support for this concept.

Based on the evidence just cited, a unified concept for the explanation of the etiology of the pathophysiologic changes occurring in the dumping syndrome has evolved (Figure 2). These changes in the dumping syndrome appear to revolve around three basic mechanisms. The early vasomotor and gastrointestinal changes occurring during or within a few minutes following the ingestion of an hyperosmolar meal are due to humoral effects of which bradykinin and serotonin are unquestionably the primary mediators. These vasomotor and gastrointestinal effects comprise the first stage of the dumping syndrome and ac-

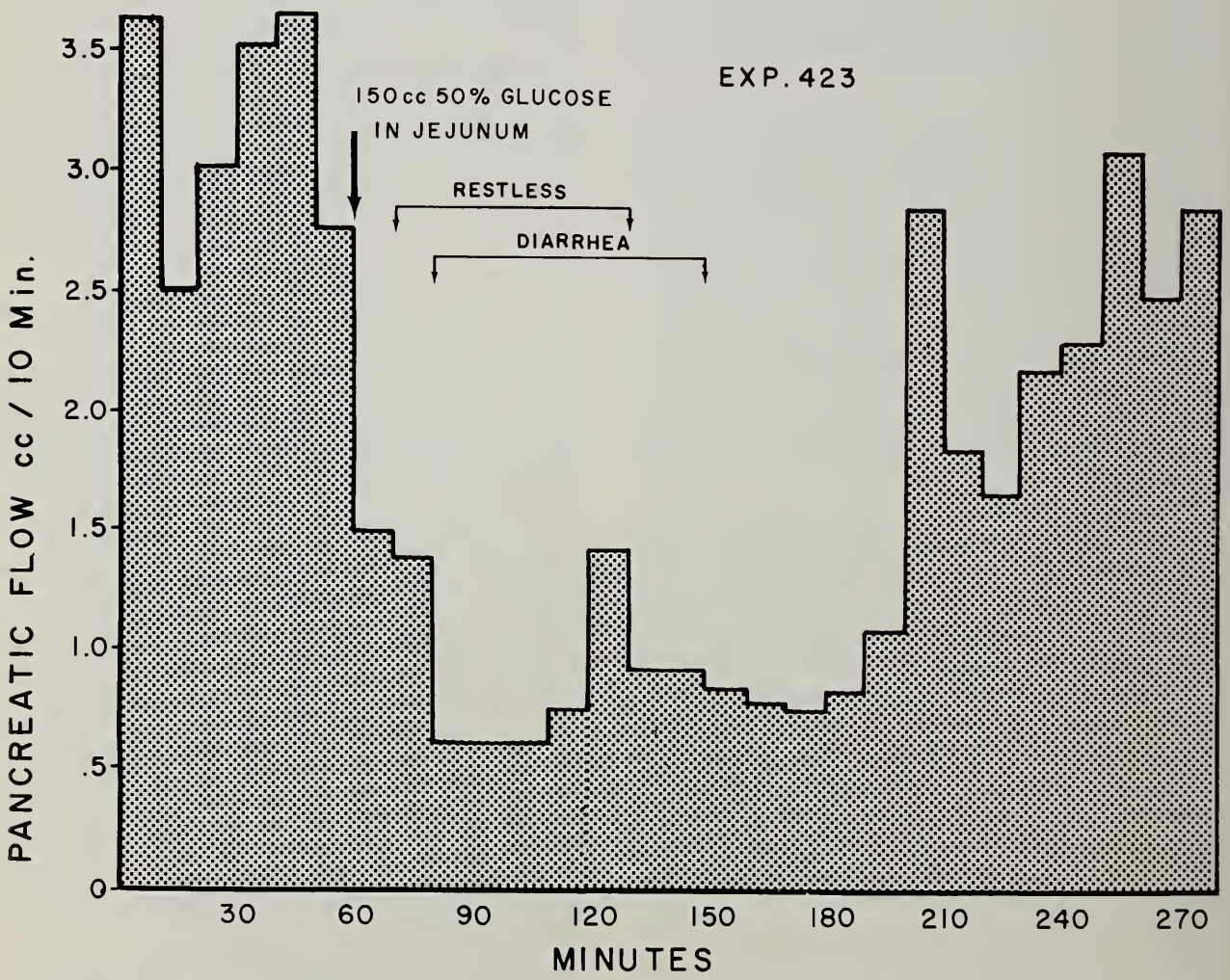


Figure 1. Effect of hypertonic glucose instillation into the proximal jejunum upon pancreatic function. A marked and significant drop in pancreatic exocrine secretion occurred in this animal which lasted for two hours. This could be reproduced in every animal studied.

count for the symptoms encountered in the majority of the patients seem. Bradykinin is probably responsible for the marked flushing and diaphoresis, while serotonin release produces increased intestinal motility and a diminution in pancreatic exocrine function.

The second stage of the dumping syndrome, occurring from 20 to 45 minutes after the ingestion of an hyperosmolar meal, appears to be related to intraluminal fluid shifts and a decrease in plasma volume. The symptoms consist of profound weakness, tachycardia and hypotension and correlate well with the hypovolemia which has been demonstrated by Roberts, Randall and their associates in their classic studies of the dumping syndrome. However, apparently due to compensatory mechanisms or perhaps to individual lack of sensitivity to fluid depletion, many patients do not demonstrate these intermediate symptoms. This explains why only equivocal results have been obtained in the treatment of these patients with rapid intravenous fluid replacement, for it can be expected that fluid volume expansion would alter only this intermediate phase and not the early vasomotor or gastrointestinal effects produced by bradykinin or serotonin.

Finally, only a small percentage of patients experience delayed or rebound hypoglycemia following hyperglycemia encountered in the dumping syndrome. This late component is perhaps not a classic dumping phenomenon but rather a manifestation of exaggerated insulin response which is possibly related to gut hormone effects on pancreatic insulin produced. It has peen postulated that the stimulus here may be the high concentration of glucose within the bowel lumen which may produce a rapid release of insulin from the pancreas. Studies have shown that this high concentration of insulin released into the portal vein is taken up to a large degree by the liver.[9] However, the subsequent release of this insulin from liver storage may occur from one to three

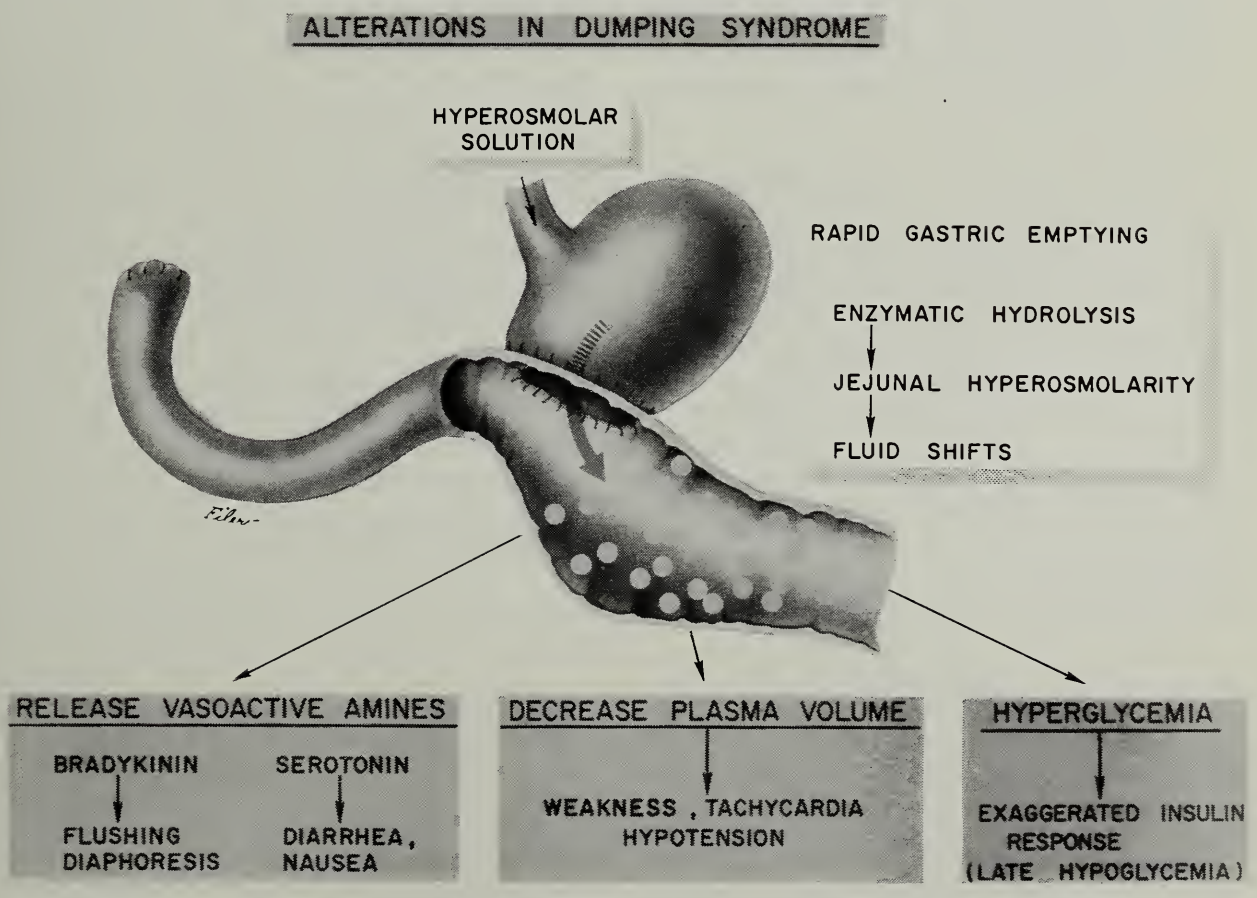


Figure 2. Unified concept of dumping syndrome.

hours later with hypoglycemia eventually occurring. Perhaps the best argument against hyperglycemia as a cause of the late symptoms in the dumping syndrome is the inability to initiate these symptoms by intravenous effusion of large quantities of glucose in these patients.

It is possible that in the future additional vasoactive hormones may be demonstrated to be significantly involved in the dumping syndrome. Nevertheless, it is clear that careful evaluation of symptoms in these patients, particularly as related to the temporal dumping sequence as outlined in Figure 2, will be extremely helpful in the understanding of this complex entity. ★★★

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WAITING TO ACCOMMODATE

On my second day in practice in a small town I was called to the scene of an accident in which two limousines in a funeral procession had collided. Several of the occupants were badly cut, so I took them back to the office with me.

There, for an hour, I debrided, stitched, and bandaged. At last I accompanied my patients to the front door, where to my horror, I discovered the entire funeral procession. It had been drawn up in front of the office the whole time—while, no doubt, the rest of the town concluded what it was there for.

—Elizabeth Proctor, M.D.

Clinical Experience With Low Molecular Weight Dextran in Acute Myocardial Infarction

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MYOCARDIAL INFARCTION is a common and serious disease. Furthermore, the record of treatment is not outstanding. Mortality experience will vary with many factors including age, patient population, concurrent illness, criterion for diagnosis, and time after onset until hospitalization. Mortality will vary in the same institution from time to time without evident cause. On the average, the hospital mortality in unquestioned infarction probably runs between 30 and 40 per cent. Furthermore, this figure has changed little in the last decade, though admittedly the impact of the intensive care concept has not yet been fully appraised. When these facts are appended to the prevalence of the disease, the limited therapeutic arsenal for this illness is disturbing.

The reported mortality is hospital mortality, meaning that the patients have survived the initial impact of the illness for the several hours required to become situated in a hospital bed and have theoretically lived long enough to be treated and are in a sense therapeutic failures.

An analysis of our hospital mortality from 1956 to 1961 showed a figure in the 40 per cent range in clearly diagnosed infarction. Our attention was consequently directed to the interval between onset and death in search of new therapeutic opportunity. The following observations were made:

(1) The severe intravascular sludging decribed first by Bloch was confirmed in all patients in some degree within 24 hours of admission.

(2) Fibrinogen often associated with abnormal aggregation was consistently elevated.

Although other groups have not found LMDx to be of value in acute myocardial infarction, the author's studies indicate that in certain circumstances it is a useful therapeutic tool. He discusses three phases of the studies at Scott and White Memorial Hospital.

(3) Serial whole blood viscosity studies were done in the belief that this property is a factor in peripheral resistance and thus a determinant of myocardial work and could be significant in this circumstance of a weakened heart and lowered blood flow rates. This parameter was not stable, commonly being erratic and elevated in the majority of cases.[1]

(4) Though only 15-20 per cent of patients were in shock as measured by the blood pressure ($m < 75$ mm.), a much larger percentage of patients showed symptoms and findings of shock, often with low central venous pressure.

Since low molecular weight dextran will prevent or reverse intravascular sludging,[2] will reduce whole blood viscosity by hemodilution,[3] and is useful in hypovolemia shock,[4] it offered some theoretic value as a therapeutic agent. This report will cover a three-phased clinical study over a seven-year period of the use of low molecular weight dextran (LMDx) (Rheomacrodex), average molecular weight 41,000, as a

From the Section of Cardiology, Scott and White Memorial Hospital.
Read before the 101st Annual Session, Mississippi State Medical Association, Biloxi, May 14, 1969.

therapeutic agent in acute myocardial infarction. Portions of the study have been reported but will nonetheless be presented in summary for completeness sake.

Phase I extended from Jan. 1, 1962, to July, 1963. Sixty-five consecutive cases of acute myocardial infarction were given LMDx by continuous infusion for the first 76 hours of the illness, 500 cc. of 10 per cent in 5 per cent glucose in 4 hours; then 500 cc. q8h. This program was designed to achieve a plasma level of about 1.00 gm. per cent and maintain same, calculated on the basis of known renal excretion rates.[5] At the completion of this study, the following conclusions were reached:[1, 6, 7]

(1) Intravascular sludging was markedly reduced.
(2) Blood viscosity was uniformly reduced.
(3) The laboratory pattern of the disease, notably EKG, SGOT, and WBC was altered.
(4) Mortality of 16.7 per cent was encouraging, but
(5) LMDx could not be given blindly, since constant infusion with inadequate excretion would over-expand plasma volume.
(6) LMDx infusion with inadequate hydration resulted in high viscid urine and was associated with oliguria and, at times, reversible hydropic changes in the renal tubules.
(7) Extremely careful monitoring of general condition, intake, urine output, urine specific gravity, and central venous pressure and appropriate dosage variation was mandatory.

Phase II of this study was designed to establish the value or lack of same of LMDx in reducing mortality and extended from July 1963 to February 1967. All patients admitted with a positive or strongly presumptive diagnosis of acute infarction less than 24 hours old were randomized into two groups on the basis of a predetermined digit in their registration numbers.

All received the accepted forms of therapy with a liquid diet for the first three to four days, plus the following:

Group A: (Control). 500 cc. 5 per cent glucose in D/W in 4 hours; then 500 cc. q8h for 72 hours.

Group B: (Treatment). Equal volumes of 10 per cent LMDx in 5 per cent glucose on the same volume schedule. LMDx was temporarily discontinued and substitute 5 per cent glucose was given if venous pressure exceeded 15 cm.; urine volume was < 250 cc./6 hours; or urine specific gravity > 1.065.

The end point of the study was death in 21 days or during hospitalization, whichever was the longer. Patients were removed from the study if they died in less than four hours or if a presumptive diagnosis was not confirmed. Patients moribund on admission or who died suddenly in the hospital without diagnosis were not placed on the study.

The total experience, less three months when LMDx was unavailable, has been reported[8] and is summarized as follows:

Total number of cases $<$ 24 hours on admission . . 136

	Group A	*Group B*
Randomization	75	61
Death $<$ 4 hours	3	1
Moribund or death without diagnosis	3	3
Failure to make presumptive diagnosis (all living)	4	12
Final number	65	45
Presumptive diagnosis not confirmed	5	1

The two groups were equivalent in age, sex, previous infarctions, known hypertension, and known diabetes mellitus. Group A had more subendocardial infarctions (6 to 1).

GROUP B FINDINGS

Serial measurements of plasma proteins showed a dilution effect in Group B. Visible sludging and blood viscosity were again markedly and consistently reduced in Group B. Serial hematocrit figures indicated plasma volume increase in Group B. Of interest was a frequent and often marked early increase in hematocrit in the control group. Water balance figures revealed the general marginal voluntary hydration in both groups and the common striking inadequacy. The average voluntary fluid intake over the first four days of hospitalization was slightly over 1,000 cc. per 24 hours in both groups and a 24-hour intake under 200 cc. was not uncommon.

It was significant that 17 of the 45 cases in Group B required reductions in dextran infusions on the basis of our established criterion for same. No instance of toxicity or vascular overload occurred.

Mortality figures showed a statistically significant difference: Group A—32.3 per cent; Group B—13.5 per cent. $p < .03$.

Our conclusions from this Phase II study were as follows:

(1) LMDx can be safely given to patients

with acute infarction if careful monitoring is maintained.

(2) The basal infusion program was too much for the average patient.

(3) Voluntary hydration of the average patient is marginal, and in the more seriously ill patient is inadequate.

(4) The therapeutic value of LMDx, when carefully used, was established.

The reason for the beneficial results was not delineated, whether from a decrease in cardiac work due to reduced blood viscosity; improved microcirculation from reduced sludging; or reduction in shock from increased plasma volume and a presumed improved microcirculation, since all changes were apparent.

TOLERANCE:BENEFIT

Phase III, currently in progress, was designed to shed light on the tolerance:benefit problem. From Phase II, it was estimated that even the very ill patients could tolerate about one half of the infused load of LMDx, and probably needed the same intravenous fluid volume. It was also decided to exclude subendocardial infarctions since they are very commonly the "presumptive diagnosis" and have a general mortality of < 10 per cent. Since a 5 per cent solution of LMDx is not commerically available, the following program of intermittent therapy was followed initially:

(1) 500 cc. 5 per cent glucose in D/W or BES in 4 hours.

(2) 500 cc. 10 per cent LMDx in 5 per cent glucose in 4 hours.

(3) 500 cc. 5 per cent glucose in D/W or BES and 500 cc. 10 per cent LMDx in 5 per cent glucose alternating q8h for 64 hours.

The usual monitoring program was continued.

The experience to date in 75 consecutive transmural infarctions is as follows:

Historical Data

Average age	61
Percentage males	80 per cent
Known past infarction	28 per cent
Known past diabetes	7 per cent
Known past hypertension	12 per cent

Incidence of Complications

Decompensation	61 per cent
Arrhythmia	43 per cent
Shock	18 per cent
Minor dose variation	18 per cent
Mortality	10/75 = 13.3 per cent
<48 hours = 5	
5th day = 2	
14th day = 2	
18th day = 1	

Conclusions in this Phase III are as follows:

(1) The favorable mortality rate was not affected by the reduced LMDx load but unchanged fluid volume.

(2) The need for dose adjustment was considerably reduced but not eliminated.

It is important to point out that others have not found LMDx to be of value in acute myocardial infarction. Borchgrevinck[9] reported on 102 cases; 45 served as controls, of which 4 died, and 57 received LMDx, of which 8 died. There is no statistical difference between these groups. Certain types of cases were eliminated from the study for various reasons resulting in a low risk group, since the prevailing mortality prior to the study at Ulleval was 40 per cent, and the overall mortality in the study was 11.8 per cent. The LMDx was given in three single infusions of 500 cc. within 48 hours without provision for additional hydration or monitoring of fluid balance. It is very difficult to compare the two studies. More recently, Borchgrevinck has advised against the routine use of LMDx in acute myocardial infarction.[10]

Reutter[11] treated 74 patients with LMDx in a dose of 25-40 ml/hr for 60-72 hours without supplemental hydration and compared them with 100 controls, not randomized but matched by the Peel Index.[12] The difference in mortality in the treated group (17.6 per cent) compared to controls (20 per cent) was not significant statistically. Reutter did conclude that LMDx was of statistical value in the treatment of cardiogenic shock without increased central venous pressure.

FURTHER STUDIES

Several other small studies have failed to show conclusive results one way or another and will not be itemized at this time.

Our more recent experience has indicated that a slow continuous infusion with additional hydration is preferable to intermittent infusion. A 5 per cent LMDx solution would be easier and safer to use for this purpose.

Finally, though LMDx has been of real value to us in the treatment of acute myocardial infarction, it should not be considered a new treatment, but rather a useful therapeutic tool to be applied to these extremely complex medical problems only under close supervision with full knowledge of its properties, values and risks.

Seven years of study and experience has led us to the following conclusions:

(1) LMDx is of no proven value in low risk cases of myocardial infarction.

(2) LMDx is of proven value in transmural infarction, less than 24 hours old, particularly with shock, when properly administered, over the first three days of the illness.

(3) The best current estimate of dosage is approximately 1 gm/Kg/24 hours, and this dosage may require a reduction in individual cases.

(4) LMDx, in this dosage, can only be given with adequate hydration.

(5) LMDx should not be given in the presence of renal failure or pulmonary edema.

(6) In the present state of our knowledge, close monitoring of central venous pressure, fluid intake, urine volume, and urine specific gravity, is necessary if LMDx is to be safely given to cases of acute myocardial infarction. ★★★

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S.R.O.

After the receptionist entered the new patient's name in the appointment book, she asked him to be seated while awaiting his turn with the doctor. To her surprise, he refused and started to pace the corridor. Finally, she said, "Sir, if you'll have a chair, you'll be more comfortable, and the doctor will see you just as soon."

His answer was a snort: "Young lady, if I could sit down, I wouldn't *have* to see the doctor!"

Carcinoma of the Esophagus: A Case Report

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CARCINOMA OF THE ESOPHAGUS is a difficult therapeutic problem. Since 1940 surgery has been the primary mode of therapy in most centers, especially in those cases where the lesion is limited to the esophagus. Goodner[1] reviewed the 260 cases resected at the Memorial Hospital from 1940 to 1966. There were 16 five-year survivors or an incidence of 6.1 per cent. One patient had survived 19 years. Preoperative irradiation had been used on 85 cases treated since 1956. This did not seem to affect the five-year survival rate, but it did appear to increase the resectability rate. In this group the resectable rate was 55.2 per cent. Moseley[2] reviewed the 56 patients with squamous cell carcinoma of the esophagus treated at the Peter Bent Brigham Hospital from 1946 to 1965, and there was a five-year survival rate of only five per cent. Nakayama[3] has combined preoperative radiation therapy with staged surgical procedures to reduce the operative mortality rate and to extend surgical resectability.

Probably the most important element in obtaining better results in the treatment of carcinoma of the esophagus is early diagnosis. Most cases presenting for treatment are in an advanced stage of the disease. The marked elasticity of the esophagus permits the patient to swallow without significant difficulty until the lumen has largely been encroached upon by the malignant mass. In the earlier stages of the disease[4] there may be transient dysphagia while eating large particles of meat or bread. Examination by fluoroscopy and barium swallow at this time may only reveal transient arrest of the contrast media at the point of the lesion. Patients with slight dysphagia which cannot be explained by roentgen examination should have esophagoscopy.[4] The lesion may thus be visualized and the diagnosis established by biopsy. Persistent dysphagia, weight loss, pain and regurgitation of food are noted as the disease progresses.

Since 1940, surgery has been the primary method of therapy for carcinoma of the esophagus, a difficult therapeutic problem. Early diagnosis may be the most important element in obtaining better treatment results. A case report with an 18-year follow-up is presented.

In the following case the patient had a carcinoma of the esophagus resected 18 years ago.

On April 1, 1951, a 50-year-old white female was admitted to the Mississippi Baptist Hospital. She complained of difficulty swallowing for a period of six months. At first the dysphagia was noted only with solid foods. Soon after the onset she consulted a physician and was told that it was due to nervousness. Later, she became unable to swallow any solid foods, experienced fullness in the chest, and often regurgitated the foods eaten. She lost 20 pounds. Roentgen examination with barium swallow revealed an obstruc-

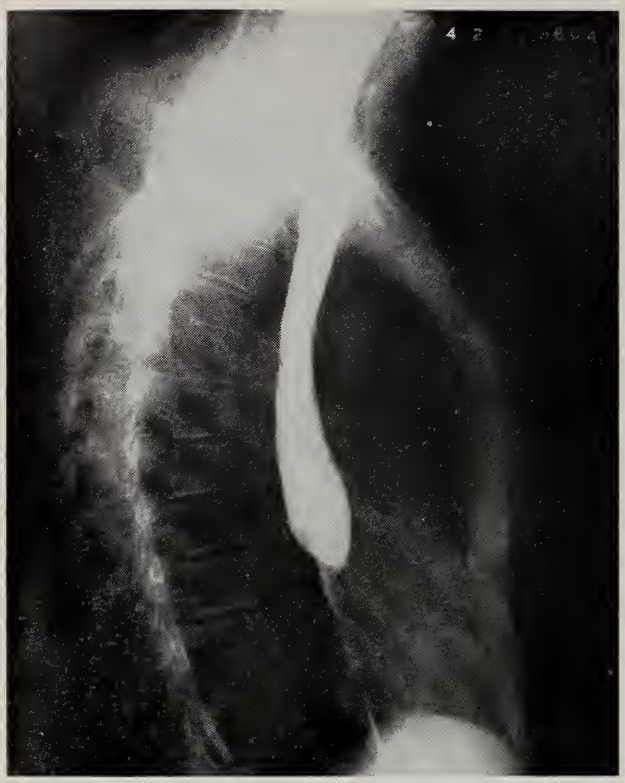


Figure 1. Esophagogram of the patient before operation showing an obstructive lesion at the level of the 9th dorsal vertebra.

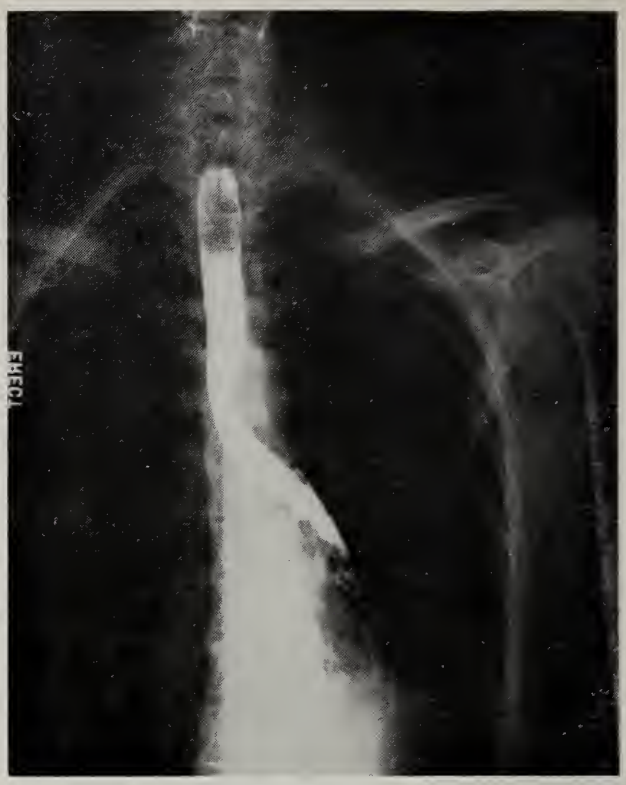


Figure 2. Esophagogram after operation with the patient in the erect position revealing a good functioning esophagogastrostomy.

tive lesion at the level of T-9 which permitted only a small flow of barium to pass beyond this point (Figure 1). The lesion was visualized at esophagoscopy and biopsy revealed a squamous cell carcinoma.

On April 6, 1951, the lower esophagus was resected and an esophagogastrostomy was made just inferior to the aortic arch. There was no evidence of lymph node involvement. Examination of the resected specimen revealed an ulcerated lesion involving a 5 cm. segment of the esophagus. The tumor invaded the muscularis and the serosa. Barium swallow performed postoperatively revealed a good functioning esophagogastrostomy (Figure 2). However, in 1956 she again developed difficulty swallowing solid foods. Esophagoscopy revealed a stricture at the site of the anastomosis. Dilatation was performed with temporary relief. The patient has refused surgery offered to correct the stricture but lives very well on a liquid diet. She was last seen in the office August 2, 1969, and was doing well without evidence of recurrence of the malignancy.

SUMMARY

Carcinoma of the esophagus is best treated by surgical excision. Several series seem to indicate that preoperative radiation increases the resectability rate. Early diagnosis should lead to improvement in the cure rate. A high index of suspicion with any patient who has difficulty swallowing regardless of how transient may lead to an early diagnosis. Such a patient should be esophagoscoped if barium swallow fails to explain the cause of dysphagia. The case of a patient with carcinoma of the esophagus resected over 18 years ago who is living and free of carcinoma is presented. ★★★

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Radiologic Seminar LXXXIX: Radiographic Differentiation Between Renal Cyst and Neoplasm

JOHN Y. GIBSON, M.D.
Jackson, Mississippi

THE DIAGNOSTIC PROBLEM of differentiating renal cyst from malignant tumor has long been a challenge to the radiological sciences. With the progress in radiographic technique and procedures of the last several decades, more accurate methods of differentiation have been made available. Since renal cysts usually do not require surgery and malignant tumors always do, the importance of accurate diagnosis is obvious.

The plain abdominal film and pyelogram will usually demonstrate the presence of a space-occupying lesion when a cyst or tumor is present but not until the advent of nephrotomography and aortography could an accurate diagnosis be made short of exploratory surgery. Now, however, with the use of these procedures to establish the diagnosis, a patient can often be saved unnecessary surgery. This is particularly significant with the elderly, poor-risk patient in whom a solitary renal mass is an incidental finding.

The plain film of the abdomen and pyelographic studies may show a number of signs which, while not diagnostic, will tend to suggest either renal cyst or neoplasm. On the plain film, a soft tissue outline of an expanding lesion will usually be identified adjacent to or overlying the kidney. The outline of a cyst will usually be rounded and smooth in contrast with the irregular contour of the solid neoplastic mass. Occasionally the wall of a cyst may be calcified and appear as a thin curved line of calcification. When calcification occurs in a renal carcinoma it will usually be centrally located and mottled in appearance.

A cyst located in the periphery and expanding outward from the kidney may not deform the renal pelvis and calyces. When lying deep within the renal parenchyma, a cyst may cause considerable distortion of calyces and pelvis as visualized on intravenous or retrograde pyelography. The calyces may be stretched, flattened, dilated, displaced or completely obliterated. These calyceal changes are nonspecific and can be seen also with malignancy. However, when these changes are due to a cyst, the most terminal portion of the minor calyces usually remains normal while a neoplasm will render the minor calyces completely abnormal and distorted. Renal cortical tumors have a tendency to extend into and invade the renal pelvis. A crater-like deformity of the renal pelvis is not uncommon and in advanced cases, the pelvis may be completely obliterated, the outline of the retrograde medium terminating abruptly in the region of the ureteropelvic junction. Large renal cysts or tumors may cause the entire kidney to rotate or twist on its axis resulting in very peculiar types of malrotation. These plain film and pyelographic signs are considered suggestive and therefore increase the probability of any given renal mass being cyst or neoplasm but can not, of course, confirm either diagnosis. Many cases, and all early cases, of either cyst or neoplasm will appear simply as a small, smoothly outlined renal mass without calcification which will deform but not invade calyces and pelvis. Fortunately now we

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Hospital.

have the nephrotomogram and aortogram to help confirm our diagnostic suspicion.

The Nephrotomogram, as the name implies, is the radiographic method of obtaining body section tomograms of the kidney during the nephrographic phase of an intravenous infusion drip pyelogram. Evans first introduced the procedure in 1954 and in 1960 he reported a 95 per cent accuracy in differentiating renal cyst from tumor using nephrotomography in 500 cases. Several others have supported this high diagnostic accuracy.

WELL DEFINED CYST

On the nephrotomogram a cyst will appear as a well defined round or ovoid radiolucent area well marginated from surrounding normal opacified parenchyma. The cyst wall is thin and an acute crescentic angle is formed by the renal parenchyma at its junction with the cyst wall.

A neoplasm will appear as an opacified mass usually of greater density than the surrounding parenchyma. In contrast to a cyst, carcinoma usually has an irregular outline and its shadow often blends with the adjacent renal parenchyma without forming a sharply defined margin. When necrosis occurs within a tumor, there may be one or more radiolucent areas with irregular, poorly defined, thick margins in contrast with the smooth, well defined, thin margins of a cyst.



Figure 1. I.V.P. on 65-year-old female showing an 8 × 8 cm. rounded mass at lower pole of right kidney. The lower pole calyces are slightly displaced.

ADJUNCTIVE PROCEDURE

While the neophrotomogram has rendered high diagnostic accuracy, the aortogram is often helpful as an adjunctive procedure, particularly in difficult cases. A renal cyst will appear on the aortogram as an avascular area with normal vessels branching out around its periphery.

When a neoplasm is present the abnormal vasculature of the tumor will appear as a collection of tiny tortuous vessels extending into the tumor in a bizarre pattern. These abnormal vessels give rise to the characteristic appearance of "tumor stain." The demonstration of pathologic vessels requires exposures at the end of the arteriographic phase and the beginning of the nephrographic phase. Pathologic vessels are usually readily identified; however, occasionally they are sparse and difficult to recognize with certainty. In such cases selective renal arteriography will help render an accurate diagnosis.

If the cyst is centrally located and surrounded by parenchyma, the avascular region representing the site of the cyst may be masked by superimposed normal renal vessels. This difficulty can be overcome by making tomograms during the nephrographic phase.

TUMOR IN CYST WALL

Tumors can occur within the wall of a cyst but the incidence is rare. When it does occur, the tumor is almost always found in the part of the cyst wall connected to solid renal parenchyma. The identification of pathological vessels within the wall of a cyst would indicate this diagnosis.

In diagnostically difficult cases percutaneous needle aspiration and injection of contrast media into a cyst can be a useful procedure. This is particularly true if the patient is inoperable due to his general physical condition. Most cysts are filled with serous fluid. If the content of a cyst is hemorrhagic, the incidence of tumor may rise to as high as 25 per cent. Aspiration of clear fluid and the radiographic demonstration of a contrast-filled smooth-walled cavity strongly supports the diagnosis of renal cyst. ★★★

University Hospital (39216)

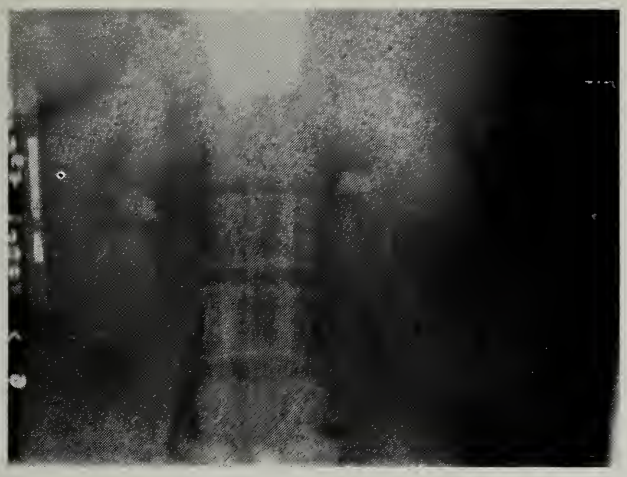


Figure 2. Nephrotomogram on same patient shows the mass to have a radiolucent center with irregular thickened border suggesting central necrosis of a tumor mass.

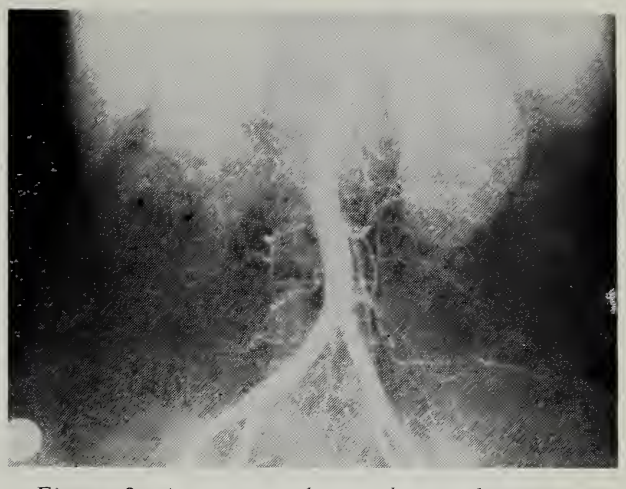


Figure 3. Aortogram shows abnormal tumor vessels in periphery of mass. Kidney was removed and found to be a carcinoma with central necrosis.

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"The world cannot continue to wage war like physical giants and to seek peace like intellectual pygmies."

—Basil O'Connor (1892-)



The President Speaking

'Basis of Excellence'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

ALMOST EVERY LEVEL of organized medicine today is taking a new interest in continuing medical education. With the rapid advance of knowledge which is occurring in every field of medicine, it is becoming increasingly apparent that continuing education on an organized basis is essential to continuing excellence of medical service.

Many organizations are developing incentive programs which encourage and reward participants in continuing education, while a few organizations have moved into mandatory requirements. The American Academy of General Practice has taken a strong lead in this area. There seems little doubt that in the future some form of periodic recertification will be the rule rather than the exception.

A postgraduate training program is under way at the University Medical Center which I feel is the beginning of a new era of continuing education. This program, under the direction of Dr. William O. Barnett, was developed in cooperation with the state medical association and the Regional Medical Program and is one of the better programs to be found in the nation. It requires 440 hours over four years and brings practical bedside training. When the announcement of this course went out, the first class was filled by return mail. More courses will follow as medicine meets its responsibility for excellence. ★★★

JOURNAL OF THE
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November 1969

EDITORIALS

The Care Delivery System: Remade in Whose Image?

I

What President Nixon said about the health care delivery system last June was not clear. A succession of events now gives the assertion definition, suggesting that the President knew exactly what he foresaw as a prognosis for the delivery system. That his diagnosis may be in error is rhetorical, because at the moment, nobody but Mr. Nixon is President of the United States.

In June, the President said that "we face a massive crisis in this area (health care delivery) and unless action is taken both administratively and legislatively to meet that crisis within the next two or three years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

In an editorial the Journal said that "since President Nixon's characterization of the problem was not precisely defined, it is difficult to say exactly what he had in mind about administrative and legislative action" (The Delivery of Health Care: A System on Trial, J.M.S.M.A. X:421-424 (Sept.) 1969). The definition has been given depth and scope by four prominent individuals: Nelson Rockefeller, Jacob Javitts, Walter Reuther, and Walter McNerney. Although they are not working together, this group cannot be described as a fan club of American Medicine. Some might be so bold as to wonder aloud if they wish us well. But this much is certain: They have every intention of remaking the health care delivery system in their own image.

II

Professor McNerney, president of the Blue Cross Association and a darling of liberal HEW Secretary Robert Finch, heads a task force on Medicaid. Now the secretary has asked Progessor McNerney to study the matter of national health insurance. The secretary's charge contains the political euphemism "national" in lieu of "compulsory," because whatever anybody says about Secretary Finch, he is above all things Madison Ave. at its slickest.

Even Professor McNerney is already a little euphemistic himself. In a recent speech, he described financing for a national health insurance program as coming from "mandated contributions." If he means a tax on everybody, he could easily say so.

It may be that President Nixon, bending a little to the near-irresistible pressures upon the White House, has permitted the study. After all, the

project lacks both Presidential endorsement and the blessing of the Congress. But it is disturbing to see the administration playing footsie with individuals and a line of thinking which would be much more at home with Hubert Humphrey than with Richard Nixon.

III

Then come Messrs. Rockefeller, Reuther, and Javitts, each accompanied by a familiar figure in shadows, Wilbur J. Cohen. Gov. Rockefeller is a long and staunch advocate of compulsory health insurance. He has unsuccessfully pursued his goal in the Empire State legislature, much in the manner of another liberal Republican governor nearly 20 years ago, one Earl Warren of California.

Gov. Rockefeller was the sparkplug of the action by the recent National Governors Conference in endorsing national health insurance, albeit via a questionable parliamentary route. He has advocated a tie with unemployment insurance where, you guessed it, the employer shells out.

Sen. Javitts is getting help from Mr. Cohen in drafting a bill for national health insurance. Trying a new tack, the Javitts bill would blow up and expand the role of Blue Cross and other major insurers by making them utilities oriented toward the consumer, not toward providers of care. Just how the senator will finance his plan isn't on the record, but it is an odds-on bet that government and the employer will bear the burden.

Walter Reuther and his Committee of 100 are still in executive session, but their plan may take on the dimensions of the McNerney approach with "mandated contributions." Reuther's record of support for the Social Security mechanism inherent in Medicare is consistent and without deviation. And he, too, has the advice of Mr. Cohen.

IV

Finally, AMA is not sitting on its hands. During the past three conventions, the House of Delegates has endorsed voluntary health insurance and prepayment financing through "tax credits." The proposal is neither new nor radical, because the oil industry has thrived on the incentive of tax credits in the depletion allowance. Major industry has depended on the 7.5 per cent credit for capital plough-back into plants and production facilities.

Most observers feel that the AMA proposal may worm its way into White House thinking. Generally, it works like this: A family of four with a federal income tax liability of $300 or less would receive full credit for purchase of comprehensive health insurance from a commercial company or Blue plan. The coverage would have to measure up in quality.

Those earning more and consequently having a greater tax liability would receive progressively less credit up to top earners who might get as little as 10 per cent on the cost of coverage.

Implicit in the plan, though at the moment unspoken, is the fact that it would wipe Medicaid off the law books. Carried to the logical extreme, it could do the same for Medicare.

All of this is to say that definitive proposals for remaking the health care delivery system are in the mill. Change *per se* is not objectionable, but change to an inflexible monolith in health care or anything else isn't good where the monolith replaces a flexible pluralistic system. We watch, worry, wait, and work with more than a little apprehension. Strange as it may seem to these giants of social planning, we are for the patient first and the system second. Monoliths by their very nature make themselves first and the individual second. Let it be hoped that everyone will strive for the day when the system works for us and we do not find ourselves working for the system.—R.B.K.



"IT'S SUPPOSED TO SAY ***ANESTHESIOLOGY!***"

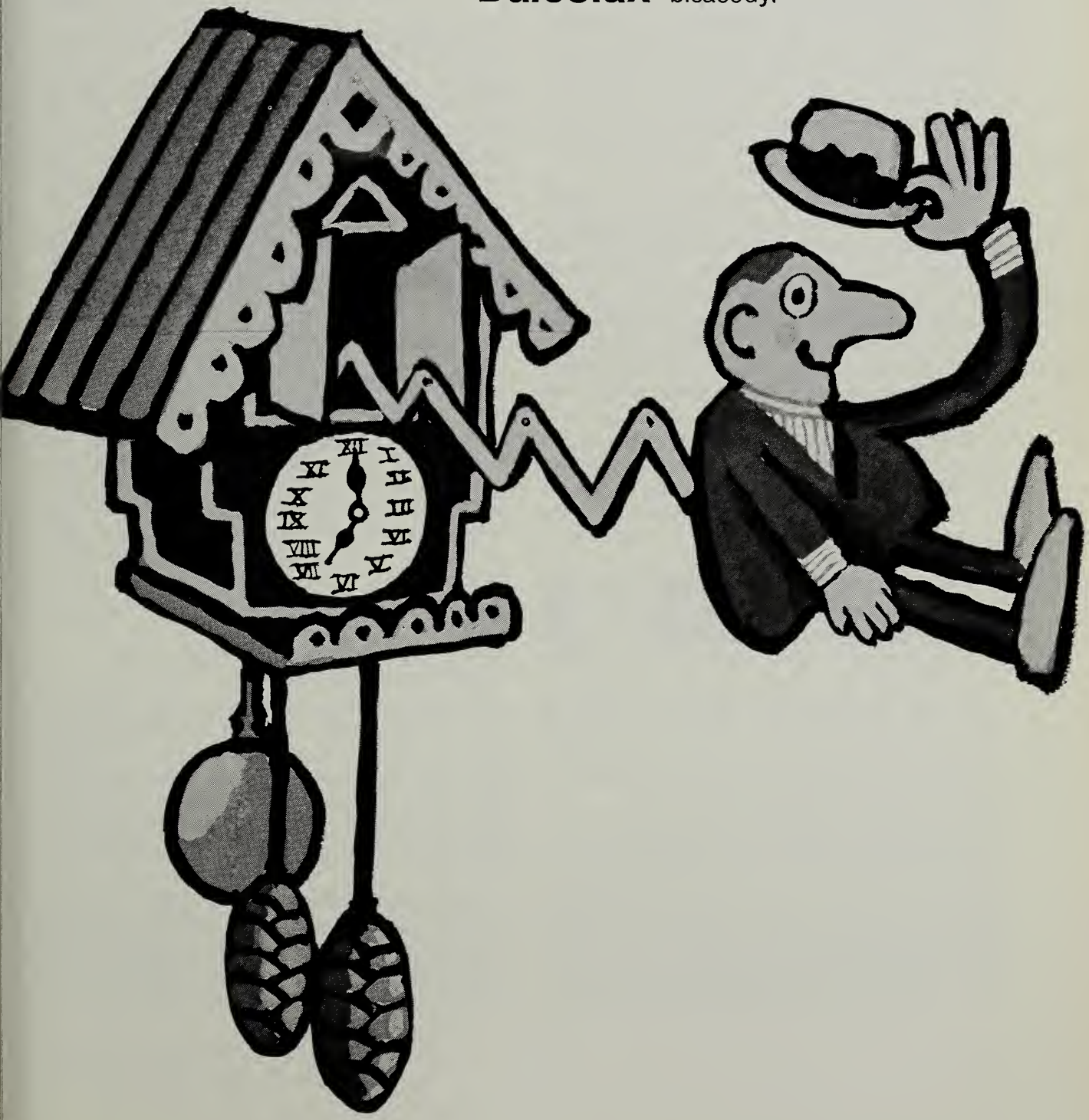
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Will Nixon Abolish OEO Extravagance?

"This federal agency will self-destruct during the present administration."

So reads a crudely lettered sign in the Washington office of the Office of Economic Opportunity, home base of the controversial antipoverty programs. And early indications noted in the Nixon administration are giving the warning more than a little credibility.

Massive failure, unbelievably defective judgment, and the useless outpouring of federal funds in many worthless projects have given OEO a public image which is not envied. The Job Corps, huge grants to street gangs, dishonesty and inefficiency, and general waste are undisputed examples.

When the Congress began to feel public pressure to do something about the poverty program in 1967, it reduced the overall OEO budget. But slipping by in the deal was an *increase* of its health and medical program budget in the same legislative enactment. Most of the health programs are not models of economy, and there is room to question quality aspects of "comprehensive social medicine" which seems to be some sort of ideal in the projects.

The administration's desire to spin off the better OEO programs to existing government agencies has heavy forward momentum. The decision to pare such controversial and often trouble-making programs, the Job Corps being a case in point, has wide public approval.

It has been wisely observed that the Johnson and Kennedy administrations committed a venal political sin when they permitted structure of OEO programs to work directly with "community action groups," bypassing the existing state and local governmental mechanisms. And the proof of the allegation seems clear enough: Imagine, if you can, the chaos of a Hill-Burton program which ignores the states and pours out funds to hospital interest groups locally.

In 1967, the Congress acted to require OEO-funded health projects to be submitted to state medical associations for review. The trouble is that OEO carries out this requirement in a perfunctory manner, largely ignoring the views of the medical profession. Certainly, this has been true in Mississippi where approval has *never* been conferred on the Tufts-Mound Bayou project by any agency of state government or by the component medical society or the state association.

What remains to be done in the fuse-burning interim, assuming the forecast of an OEO blow up to be imminent, is for the Congress to put review teeth in the funding applications, both for state governments and private groups thereby affected.—R.B.K.

The Price Tag on Liability Coverage

The problem of insuring against suits for malpractice is becoming intolerable for the American medical profession. In some few states, the tab is upwards of $5,000 to $10,000 per year for realistic coverage. In most states, the price tag on the professional liability policy hovers at or above $1,000 for the usual (and now inadequate) limits of 100/300.

But in Mississippi, a positive program initiated by the association's Board of Trustees has actually produced a lowering of professional liability premiums, and *Mississippi physicians currently enjoy the lowest premium rates in the nation.*

As has been pointed out, this savings alone is more than enough to cover the costs of local, state, and AMA dues each year with a little bonus left over.

But there is no guarantee of this blissful state of affairs, and the nature of the beast is such that the picture can change almost overnight. Each state is experience-rated by the insurance industry and by each company writing the coverage. When losses or expenses exceed premium income, then the premium rates are raised. And the state insurance commissioner monitors the process, assuring that the market is orderly and fair.

The association's Board of Trustees has long advocated executive session review on threatened or actually instituted litigation. Submission of such matters remains a prerogative of the affected physician, as it should and must. But where professional liability matters are submitted, the record is remarkably good and indicative that causes without merit are quickly and easily weeded out. And that's most of them, too.

Members are encouraged to confer with their Trustee in these distressing matters, permitting him to assist along with his colleagues. It is a proven policy of value to the practitioner. Just look at the bill, and you'll agree.—R.B.K.

A New Definition of Fetal Life

A conviction by an Ohio court of vehicular homicide for causing the death of a seven-months viable fetus may be a little-noticed landmark decision. The defendant was under the influence of intoxicants.

The pregnant mother-to-be was injured in the accident found to be the fault of the DWI. The fetus was born 36 hours after the mishap, an autopsy disclosed that death was due to hypoxia related to placental hemorrhage resulting from uterine contusion.

The pathologist testified that the fetus could have, under reasonable medical probability, survived outside the mother's body. The Ohio vehicular homicide statute clearly limits the crime to the death of a "person," and existing case law limits "person" to a living individual. On the basis of medical evidence, this legal definition has been extended by the courts.

Suggested in the decision are new areas of further legal definition, such as rights of the unborn, as was apparent in this case, inheritance, property, and probably just about everything except liability.

Crucial to such further decisions are medical evidence and learned scientific opinion. The decisions in future cases may be made difficult where the moment of capability of life independent of the mother is at question or where the fetal death is the only fatality at litigation.

The case in point is *State of Ohio v. Dickinson, 248 N.E. 2d 458 (Ohio, June 4, 1969),* and it will not be the last.—R.B.K.

Yin and Yang: Villains of Disease

Watch the balance of yin and yang, say the traditional Chinese herb doctors, or you're a sick man.

The Wall Street Journal reports that 6,000 pharmacies in Taiwan (Nationalist China) stock herb remedies ranging from wine of tiger bone for rheumatism therapy to skull cap of deer with which to treat liver maladies.

The 50-century old practice of herb medicine is a licensed profession in Taiwan, and it ignores such upstart Western diagnostic techniques as x-ray and laboratory tests and recent remedies of antibiotics. The school is distinctly separate from acapuncture, the silver needle treatment which has got to be worse than the disease.

Western physicians find herb medicine diagnosis the major area from criticism, the report says. This consists of taking the pulse in each arm of the patient up to nine times.

The yin and yang bit is the clincher, however. These are said to be opposing forces in the body. Yin is passive and dark, while yang is active and light. The *WSJ* reports that when the patient has a cold, for example, the herbalists lay the charge to an overabundance of yang which causes the fever.

Almost in parallel to European and Middle-East ancients, the Chinese herb doctors believe that the body is made up of five elements: wood, fire, earth, metal, and air. Each element, moreover, has yin and yang, so in a complex disease condition, the herb doctor has a delicate task in prescribing the right herbs and animal derivatives to get everything just right.

But it all isn't a joke, because Bristol Laboratories has an installation in the Far East which is studying some of the potions used. For example, the herbalists have used the twig of ma huang for treatment of asthma for thousands of years. Ma huang yields up ephedrine. Recently, one herb produced an analgesic 90 times more powerful than morphine, but in laboratory animals, it also produced violent tremors, so it was dropped as a potential addition to the armamentarium of Western medicine.

So take your choice: quackery, coincidence, or perhaps the merging of the ancient with the new in the boundless realm of science. But in any event, watch that yin and yang.—R.B.K.

POSTGRADUATE CALENDAR

CURRENT CONCEPTS IN GYNECOLOGIC CANCER

University Medical Center, Jackson
November 13, 1969, beginning at 9:00 a.m.

Sponsored by the University School of Medicine Postgraduate Education Committee and the Department of Obstetrics-Gynecology

Participants:

Richard C. Boronow, M.D., associate professor of obstetrics-gynecology and director, gynecologic tumor service, The University of Mississippi School of Medicine

Henry A. Thiede, M.D., professor of obstetrics-gynecology and chairman of the department, The University of Mississippi School of Medicine

Carl G. Evers, M.D., associate professor of pathology, The University of Mississippi School of Medicine

Roger B. Arhelger, M.D., associate professor of pathology, The University of Mississippi School of Medicine

This intensive one-day course is designed to cover the diagnostic approach to the patient suspected of having a gynecologic malignancy and the therapeutic principles once diagnosis is established. The course will emphasize clinical considerations: differential diagnosis, diagnostic techniques, therapy, and follow-up. Because of the brevity and depth of the course, registration will be limited to no more than five. Topics for discussion will include cervical cytology, principles and pitfalls; evaluation of the pelvic mass; evaluation of abnormal uterine bleeding; diagnostic techniques; carcinoma in situ of cervix; invasive cancer of the cervix; endometrial cancer; ovarian cancer; trophoblastic disease, and cancer of the vulva and vagina.

WEEKLY CANCER CONFERENCES

University Medical Center, Jackson
Time: 1-2 p.m.

Supported by a United States Public Health Service Clinical Cancer Training Grant and the Mississippi Regional Medical Program

November 5

New Hope for Childhood Leukemia
Robert E. Carter, M.D., Moderator
Jeanette Pullen, M.D.
H. L. Reid, M.D.
Warren Bell, M.D.

November 12

Case Presentations: Pediatrics
Robert E. Carter, M.D.
Charles Pratt, M.D.

November 19

Wilm's Tumor: Current Concepts
Robert E. Carter, M.D., Moderator
Nell Ryan, M.D.
Bernard Hickman, M.D.
W. Lamar Weems, M.D.

December 3

Inherited Human Cancer
John Jackson, M.D.

December 10

Management of Larnyx Cancer
Bernard Hickman, M.D., Moderator
Howard Cheek, M.D.
Myron Lockey, M.D.
Ottis Ball, M.D.

December 17

Rehabilitation of the Laryngectomy Patient
Howard Cheek, M.D., Moderator
Godfrey Arnold, M.D.
Myron Lockey, M.D.

CIRCUIT COURSES

Northern Circuit

Tupelo—November 18—Session 2
North Mississippi Medical Center, 7 p.m.

Greenwood—October 30—Session 2;
November 6—Session 3
Greenwood Leflore Hospital, 7 p.m.

Session 2—Diagnosis and Management of Rheumatoid Arthritis
Dr. Thomas E. Wilson, III
Anatomical Factors in Gall Bladder Surgery
Dr. Edward M. Lowicki

Session 3—The Diagnosis of Cardiac Disease
In Children, Dr. David Watson
In Adults, Dr. Patrick Lehan

FUTURE CALENDAR

November 3-7

Gastrointestinal Disorders Intensive Course

November 6

Circuit Course, Greenwood

November 6-7

Workshop on the Physiology and Pharmacology of Smooth Muscle

November 13

Current Concepts of Gynecologic Cancer

November 18

Circuit Course, Tupelo

December 4

Dermatology Seminar

January 6, 1970

Circuit Course, McComb

January 8

Circuit Course, Hattiesburg

January 19-23

Cancer Chemotherapy Intensive Course

January 27

Circuit Course, Columbus

February 5

Circuit Course, Hattiesburg

February 9-13

Radiology Intensive Course

February 11

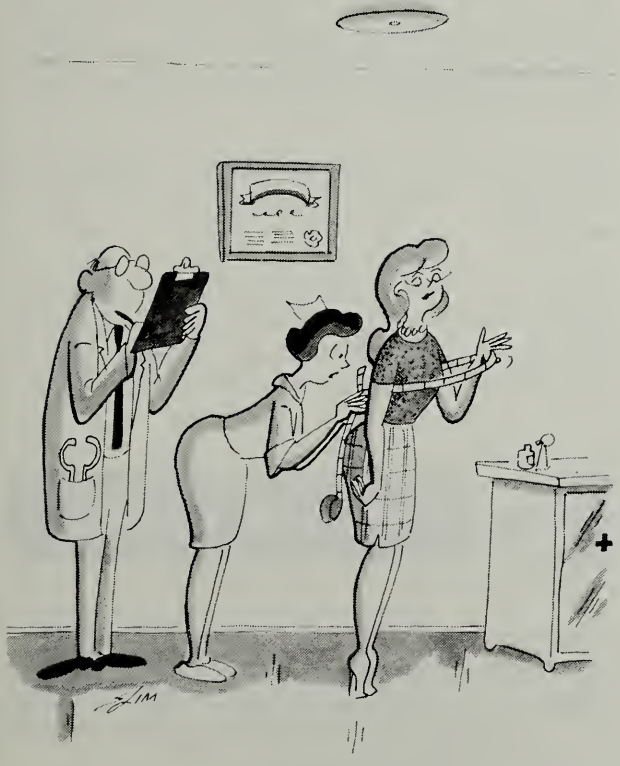
Seminar on Back Pain

February 17

Circuit Course, Natchez

February 24

Circuit Course, Columbus



March 2-6

Renal Disease Intensive Course

March 12

Circuit Course, Hattiesburg

March 16-20

Cardiology Intensive Course
Stroke Intensive Course

April 1-3

Cardiovascular Seminar

April 7

Circuit Course, McComb

April 16

Mississippi Thoracic Society, Jackson

April 21

Circuit Course, Columbus

May 11-14

Mississippi State Medical Association

PERSONALS

Tom E. Benefeld, Jr. and J. R. House, Jr., both of Gulfport, have set up temporary offices in the aftermath of Hurricane Camille at 400 Pass Road in a trailer behind the Gregory Medical Clinic.

T. N. Braddock of West Point reopened his office at 201 Jordan Avenue Sept. 2, 1969. Dr. Braddock has been doing postgraduate work at John Gaston Hospital in Memphis.

Paul B. Brumby of Lexington recently addressed a board meeting of the Mississippi State Medical Auxiliary at Primos in Jackson. Dr. Brumby spoke on sex education in the schools.

Webster Cleveland, Jr., of Booneville has been elected president of the medical and dental staff of the Northeast Mississippi Hospital for the coming year. Other officers are: D. F. Crowe, vice president, and W. W. Strange, secretary.

M. L. Dodson and John B. Levens, both of Bay St. Louis, have moved their Bay-Waveland Clinic to 641 Dunbar Avenue, formerly the Martinolich Clinic.

JOHN G. DOWNER has begun general medical practice in Lexington in the former HARRY CAUSEY clinic at the corner of Tchula and Telegraph streets. Dr. Downer, a graduate of the University Medical Center in Jackson, recently finished a two-year tour of duty with the army.

ALLAN PERCY DURFEY, JR. of Canton has joined the Durfey Clinic there for general practice and surgery. He will be associated with A. P. DURFEY and JOHN R. DURFEY.

J. F. ECKFORD of Starkville has been awarded a special letter, certificate and pin by the local Selective Service Board for 25 years of uncompensated service to the nation.

BEN P. EVANS of Grenada, RICHARD FLOWERS, HOWARD NELSON, GUY SHARPE and JOHN WOFFORD, all of Greenwood, are currently serving as advisors to the Delta Medical Assistant Association, a component chapter of MAMA.

CHARLES E. FARMER of Columbus announces the opening of his office in the Medical Arts Building at 221 7th Street North for the practice of general and chest surgery.

G. B. FLAGG of Gulfport has announced that his office is open at 205 Gulf National Bank Building from 9-5 daily.

A. G. FLYNN of Gulfport has moved to new offices at 238 Courthouse Road.

REXEL GOODMAN of Cary announces the reopening of his office there for the practice of ophthalmology.

JOHN V. GWIN of Laurel announces the removal of his office to 501 5th Avenue, the Gulf Building of his office there for the practice of ophthalmology.

JAMES D. HARDY and PATRICIA MOYNIHAN, both of Jackson and UMC, addressed the transplantation symposium of the American College of Physicians southeastern regional annual meeting at Point Cleaf, Ala.

VERNER S. HOLMES of McComb, TEMPLE AINSWORTH, WILLIAM E. LOTTERHOS, GUY CAMPBELL, all of Jackson, EDLEY H. JONES, of Vicksburg, GILBERT R. MASON, of Biloxi, and RHEA L. WYATT, of Holly Springs, have been appointed by Governor John Bell Williams to the new State Health Planning Advisory Council. The Council will assist the Division of Comprehensive Health Planning. Physician Ex Officio members include HUGH B. COTTRELL of Jackson.

HERBERT G. LANGFORD of Jackson and W. J. HUDDLESTON of Hattiesburg addressed the organizational meeting of the Central Mississippi Diabetes Association in Jackson recently. Their topic was "Diabetes—Past, Present, and Future."

HUGH MCLEOD, UMC radiology instructor, and THOMAS KILGORE, clinical instructor in surgery, spoke at the first 1969 circuit course at Tupelo. Their topics were new techniques for finding and treating diseases of the blood vessels in the arms and legs.

ROBERT R. RESTER of Jackson announces the relocation of his office for the practice of family medicine at the Family Medical Clinic in McLaurin Mart, effective the first of October.

JOE C. SCOGGIN, of Jackson, will see patients in the office of C. DUANE BURGESS of Hattiesburg for the practice of psychiatry in the Medical Arts Building at 405 South 28th Avenue on Thursday of each week. Dr. Scoggin will treat patients at the Newton Hospital every Monday.

JETSON P. TATUM of Meridian attended a fall seminar for Aviation Medical Examiners in Oklahoma City, Okla. Dr. Tatum has been a senior flight examiner for the Federal Aviation Agency for a number of years.

C. D. TAYLOR, JR. of Pass Christian and GUY CAMPBELL of Jackson recently attended the National Conference for RMP Coordinators, Directors, and Chairmen of Regional Advisory Groups in Warrenton, Va.

R. D. WARD has opened offices in the Medical Building at Raymond for the general practice of medicine.

ELBERT A. WHITE, III, formerly of Corinth, has joined the staff of the Northeast Mississippi Hospital in Booneville. Dr. White, a pediatrician, is a Diplomate of the American Board of Pediatrics.

DEATHS

AIKEN, JAMES WILSON, Whitfield, M.D., University of Mississippi School of Medicine, Jackson, 1966; interned Parkland Memorial Hospital, Dallas, Texas, one year; received Leathers Dean's Award; died Sept. 10, 1969, aged 28.

Book Reviews

The Care of the Geriatric Patient. By E. V. Cowdry, Ph.D. Sc.D. (Hon.), Consultant to the Jewish Hospital of Saint Louis. 406 pages with illustrations. St. Louis: The C. V. Mosby Company, 1968. Third edition, $15.75.

In approaching the many disciplines involved in the care of the geriatric patient, the editor has combined his talents along with those of thirty-nine contributors to cover the many facets involved in attending the total health needs of these individuals. He has produced a reference guide that takes one almost within the elderly patient in order that his specific problems and viewpoint may be seen, and then offers experienced counsel to help in meeting the problem at hand.

The text is introduced by several chapters devoted to the relationships between the patient and his doctor, his family, his community and his church, which yield a great deal of insight into the care of these individuals. Actual medical care is introduced by sections discussing the evaluation of the functional capacity of the patient and the presence of irreversible or of correctable changes. The "Geriatric Medical Checkup" gives very informative data evaluation of a routine physical examination, and recommended laboratory studies. There are sections devoted to anesthesia, dermatology, nutrition, ophthalmology, orthopedics, otorhinolaryngology, and surgery, all focused on this specific area of life. In the section on surgery, there is a very comprehensive portion directed toward preoperative evaluation and postoperative care, which is most informative. Other chapters concern psychiatry, sexual behavior and the importance of exercise.

In other areas, the great value and importance of rehabilitation are brought out in a very interesting manner, along with discussions on hospitalization and nursing care, as well as living arrangements for the elderly patient.

There is very good arrangement of the material with a very comprehensive indexing which, along with the above, make this an excellent reference book as well as good reading.

TOM H. MITCHELL, M.D.

Synopsis of Pathology, 7th Edition. By W. A. D. Anderson, M.D. and Thomas M. Scotti, M.D. 930 pages with illustrations. St. Louis: The C. V. Mosby Company, 1968. $10.50.

This review can serve no better service than to remind the profession of the availability and usefulness of this excellent work.

Because of the unprecedented growth in this field in recent years, the term "synopsis" in the title is almost a misnomer. For instance, this seventh edition has 957 pages (including the index), with 408 illustrations and three color plates. It is a concise, well-organized and lucid textbook of pathology.

The authors indicate in their preface that their chief targets in the profession have been ". . . students in courses in general and systemic pathology, to clinicians who must maintain familiarity with the foundation sciences of medical practice, and to others in medical and paramedical fields who need knowledge of disease processes." I would say that this should include all practitioners of medicine, generalists or specialists.

There has been considerable revision in this new edition, with all chapters "updated" and the addition of a chapter dealing with ultrastructural and cytochemical features of normal and injured cells, cytogenetics, and inheritance patterns.

The following definition of pathology, approved by the College of American Pathologists, indicates the need for almost constant revision of such a valuable work as this: "Pathology is that branch of natural science which treats the causes and nature of disease, together with the anatomical and functional changes incident thereto; the practice of human pathology is that specialty in the practice of medicine which may contribute to the diagnosis, treatment, observation and understanding of the progress of disease or medical condition in the human subject by means of information obtained by morphologic, microscopic, chemical, microbiologic, serologic or any other type of laboratory examination made on the patient or on any material obtained from the human body."

In summary, this book is recommended for all physicians.

KENNETH M. HEARD, M.D.

New Books Received

Plastic and Maxillofacial Trauma Symposium. By Nicholas G. Georgiade and seven coeditors. 214 pages with 390 illustrations. St. Louis: The C. V. Mosby Company, 1969. $25.00.

Manual on Artificial Organs, Volume I, The Artificial Kidney. By Yukihiko Nose, M.D., Ph.D. 275 pages with 401 illustrations. St. Louis: The C. V. Mosby Company, 1969. $27.75.

Urinary Tract Infection in Childhood and Its Relevance to Disease in Adult Life. By Victoria Smallpiece, M.D. 142 pages with illustrations. St. Louis: The C. V. Mosby Company, 1969. $9.50.

A Synopsis of Contemporary Psychiatry. By George Ulett, M.D., Ph.D. and D. Wells Goodrich, M.D. 321 pages. St. Louis: The C. V. Mosby Company, 1969. $9.50.

Textbook of Pediatrics. By Waldo E. Nelson, M.D., Victor C. Vaughan, III, M.D. and R. James McKay, M.D. 1590 pages with 527 illustrations. 9th edition. Philadelphia: W. B. Saunders Co., 1969. $21.50.

Surgeon's Choice. By Frank Slaughter. New York: Doubleday and Company, Inc., 1969.

NEW MEMBERS

The following physician has been elected to membership by his component Medical Society in the Mississippi State Medical Association and the American Medical Association.

Boronow, Richard Carlton, Jackson. Born Appleton, Wisconsin, Dec. 18, 1933; M.D., Northwestern University Medical School, Chicago, Ill., 1959; interned Cook County Hospital, Chicago, Ill., one year; obstetric and gynecology residency, Evanston Hospital, Ill., July 1, 1960-June 30, 1963; general surgery residency, Memorial Hospital for Cancer, New York City, N. Y., July 1, 1963-June 30, 1964; fellowship, Anderson Hospital & Tumor Institute, Houston, Texas, July 1, 1964-June 30, 1965; elected Aug. 5, 1969 by Central Medical Society.

LETTERS

Sirs: I would like to report the following clinical résumé as a case history of a convulsion following IV administration of Robaxin.

D. S. A 17-year-old, white male, was admitted to The Greenwood Leflore Hospital August 11, 1969. He complained of pain in his neck.

Present illness: Eight days before admission, he was in an automobile accident. The car in which he was riding was struck by another car. His neck jerked. He thinks he was unconscious for a few seconds. I saw him the day after the accident, gave him tetanus toxoid, as he had several abrasions.

Three days after the accident, the abrasion on his head was dressed. He complained of a headache, and increased pain in his neck. Three days later there was still pain and stiffness in his neck. Eight days after the accident, the pain and stiffness in his neck continued, so he was admitted to the hospital. He had been treated with Fiorinal, Maolate, and Myoflex ointment.

Past history: The patient has had no epilepsy. He had a T & A. He has had a hurt foot, and a fractured forearm. He has had colds, no other operation, and no other serious illness.

Family history: There is no family history of epilepsy.

Physical examination: There was no thyroid or glandular enlargement, no masses in his neck. There was stiffness and tenderness of the neck, and muscle spasms. There was limitation of motion in all directions. The rest of the physical examination was essentially negative.

X-ray of the cervical spine showed minor limitation of motion, suggestive of muscle spasm. There was no visible evidence of fracture or dislocation. None of the disk spaces were narrowed. The intervertebral foramina were normal in size. The x-rays of the lungs were clear; there was some visualization of the base of the skull, which showed no abnormality. X-rays of the skull were negative. His hemoglobin was 16.6 gms, hematocrit 49 per cent, white count 6,150, 46 segs. 4 eosinophile, 45 lymphs, 5 mono. His urine was negative, sp. gravity 1.026.

On the afternoon of admission, his blood pressure was 130/90. He was given one Robaxin tablet (Robaxin 750). On the morning after admission, he was given Darvon 65 Compound capsules, and cervical traction with a three pound weight.

At 11:00 a.m., the morning after admission, an ampule of Robaxin was slowly injected intravenously through a #25 needle. It is hard to inject Robaxin through a #25 needle, and it took more than five minutes to inject the 10 cc. Immediately after the injection, the patient had a convulsion lasting about a half minute. An oxygen tent was put over the patient. He was given 1 cc of Decadron intramuscularly. He was lethargic for awhile. He was pale. His pulse was strong and slow. His pulse was not counted, but it was in the vicinity of 50 or 60. Adrenal (3 m) was given intramuscularly. He became shaky. His sweating and coldness disappeared.

By 1:30 p.m., he was awake, alert, and his color was good. At 5:45, the oxygen was discontinued, and cervical traction was in place. At 8:00 p.m. there were no complaints.

On August 13, 1969, physiotherapy (diathermy, ultrasound, and hydrocollator packs) was started. He was alert, and there were no residua of the convulsion. On the 16th, the pain and spasm of the neck muscles were improved. He was discharged on the 20th. He was to use traction periodically at home, take Darvon Compound, and wear a cervical collar when uncomfortable.

When last seen on August 29, 1969, he had some pain on hyperextension of his neck.

Discussion: According to the PDR, page 1026, 1969 edition, 25 cases of syncope were reported following the administration of 1 million ampules of injectable Robaxin.

The onset of convulsive seizures during intravenous administration of Robaxin was reported in six cases, twice in known epileptics. It is to be noticed that this patient has no history of epilepsy and no family history of epilepsy. He did have possibly a mild cerebral concussion, but this is not too clear from the history.

The PDR reports no cases of fatalities following intravenous Robaxin.

EDWIN M. MEEK, M.D.
GREENWOOD, MISS.

UMC Sponsors Cancer Conferences

The University Medical Center at Jackson has initiated a new postgraduate series for 1969, Wednesday Cancer Conferences. Programs will be held in the School of Nursing Auditorium from 1-2:00 p.m. each Wednesday.

The weekly conferences on various aspects of current diagnosis and management of cancer are supported by a United States Public Health Service Clinical Cancer Training Grant and the Mississippi Regional Medical Program.

Coordinators for the series are Dr. Richard Boronow, associate professor of obstetrics and gynecology, and Dr. Carl Evers, associate professor of pathology. No registration is required and the programs are open without fee to all physicians, medical students, nurses and allied health personnel.

Topics already covered this year include different therapies for breast cancer, general surgery, epidemiology of human cancer, viral etiology of cancer, and evidence for viral etiology of leukemia.

Future scheduled programs are: Nov. 5—seminar: New Hope for Childhood Leukemia; Nov. 12—case presentations: Pediatrics; Nov. 19—seminar: Wilm's Tumor: Current Concepts; Dec. 3—lecture: Inherited Human Cancer; Dec. 10—seminar: Management of Larnyx Cancer; and Dec. 17—seminar: Rehabilitation of the Laryngectomy Patient.

Cancer conference programs for early 1970 dates will be published later. Coffee and sandwiches are served prior to each meeting.

Participants include UMC faculty members from the departments of surgery, radiology, medicine, preventive medicine, obstetrics and gynecology, pediatrics, microbiology, neurosurgery, urology, and clinical laboratory sciences. Out of state lecturers are Dr. Charles Pratt, St. Jude Children's Research Hospital, Memphis; Dr. W. Plain Myers, Chairman, Department of Medicine, Memorial Hospital for Cancer and Allied Disease, New York; and Dr. H. L. Reid, M. D. Anderson Hospital and Tumor Institute, Houston, Texas.

For further information, write: Postgraduate Education, University Medical Center, Jackson, Mississippi 39216.

Auxiliary Seeks Historical Information

The South Mississippi Medical Auxiliary has asked that anyone with information on the early history of medicine in Forrest County (the Hattiesburg area) please relay that information to any auxiliary member.

Mrs. E. W. Green said securing this data is a new project of the auxiliary. Old documents, pictures, records, letters, etc. will be used.

UMC Ups Faculty to Record 155

The University of Mississippi School of Medicine has increased the faculty to a record 155. Included are two new professors and the balance are at the assistant professor and instructor levels. Appointments not previously announced follow.

Dr. Hugh Lawrence Keegan, professor of preventive medicine, was formerly chief of entomology, department of preventive medicine, at Brooke Army Medical Center Medical Field Hospital Service School. He received his Ph.D. from The State University of Iowa. Retired from 27 years in the Army, Dr. Keegan has served as Commanding Officer, 1st Malaria Survey Detachment, Philippine Scouts, Clark Air Force Base, Republic of the Philippines; and as entomologist, department of entomology, Walter Reed Army Institute of Research, Washington, D. C. He was also Commanding Officer, United States Army Medical Command, Japan. Prior to his appointment, Dr. Keegan was a medical entomologist, geographic pathology, Division Armed Forces Institute of Pathology in Washington, D. C.

Dr. Richard Charles Miller is an assistant professor of pediatrics (surgery) and assistant professor of surgery. Previously an assistant professor of pediatric surgery at Western Reserve University School of Medicine, he received an A.B. and an M.D. from Harvard University. He interned and took his residency at University Hospitals of Cleveland.

Dr. Alfred Brann is a new assistant professor in the department of pediatrics. In addition, Dr. Brann is an assistant professor of medicine and an instructor of physiology-biology. His B.A. is from Vanderbilt University and his M.D. is from Tulane University School of Medicine. He served his internship at Vanderbilt University Hospital and did residencies at Vanderbilt University Hospital, University of Virginia Hospital, and Massachusetts General Hospital. Dr. Helen Barnes has joined the department of obstetrics-gynecology as assistant professor. Dr. Barnes received her A.B. from Hunter College and her M.D. from Howard University School of Medicine. She was an intern and a resident at Kings County Hospital.

New psychiatry faculty in addition to Dr. Stewart Agras, Chairman, whose appointment was announced in the August, 1969, issue of JMSMA, are assistant professors of (psychology) Dr. Tommy Stigall, who has his B.A. from Baylor University and his Ph.D. from Louisiana State University, and Dr. David H. Barlow, with an A.B. from Notre Dame, an M.A. from Boston College, and a Ph.D. from The University of Vermont.

Family Practice Board Gives First Exam

The American Board of Family Practice announces that it will give its *FIRST* examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 28-March 1, 1970. Information regarding the examination and eligibility for the examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary; American Board of Family Practice, Inc.; University of Kentucky Medical Center; Annex # 2, Room 229; Lexington, Kentucky 40506.

Dr. Butler Gets JMSMA Post

Dr. Frank L. Butler, Jr., of McComb has been named to succeed the late Dr. B. B. O'Mara of Biloxi as a member of the association's Committee on Publications. The constitutional body supervises and oversees production and operation of the JOURNAL.

The announcement came from Dr. James L. Royals of Jackson, president of the association who appointed Dr. Butler to serve Dr. O'Mara's unexpired term through the 1970 annual session.

The six-member body consists of the three editors and three members appointed for terms of three years each by the Board of Trustees. Dr. Lawrence W. Long of Jackson chairs the committee. The third appointee is Dr. William E. Lotterhos of Jackson.

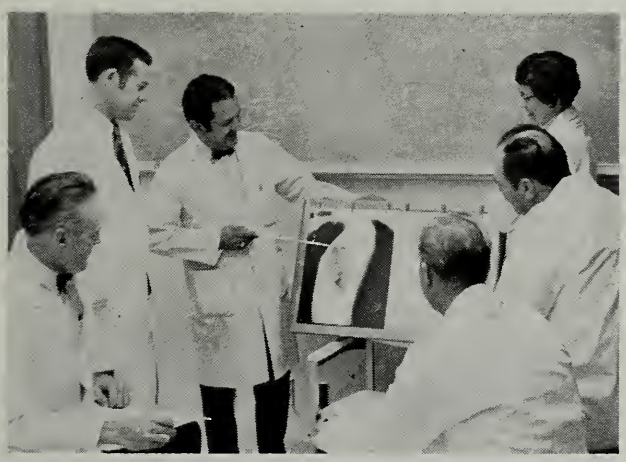
Editors are Drs. W. Moncure Dabney of Crystal Springs, editor, and George H. Martin of Vicksburg and Thomas W. Wesson of Tupelo, associate editors.

Dr. Royals acted pursuant to the By-Laws requiring the president to fill by appointment any vacancy occurring during an association year.

Mississippi Postgraduate Institute in the Medical Sciences Opens at Medical Center

The concept of a Mississippi Postgraduate Medical Institute, approved by the House of Delegates at the 100th Annual Session, has become a reality.

Designed for physicians in general practice and presented with the cooperation of professional and voluntary health organizations, the carefully structured institute concept includes attendance at two weeklong intensive refresher courses at the Medical Center each year, 15 hours per year in approved seminars and circuit courses, and 15 hours per year at medical and professional society scientific sessions.



Five family physicians from across the state were participants in a pediatrics intensive refresher course at University Medical Center in early October. It was the first in a series of one-week programs offered this year through the new Postgraduate Institute in the Medical Sciences, supported by Mississippi Regional Medical Program funds. In a radiology session with Dr. Jose M. Montalvo, UMC associate professor of pediatrics and a course instructor, at third left, are class members from left, Dr. J. H. Shoemaker of Okolona; Dr. J. Edward Hill of Hollandale; Dr. Montalvo; Dr. Marion V. Green of Holly Springs; Dr. D. C. Rudeen of Picayune; and Dr. H. F. Campbell of Wiggins.

There will also be a continuation of the one-time seminars and circuit courses. This category of training will constitute electives as will medical society meetings and hospital staff programs.

As stated by the House of Delegates, "The Institute will serve both physicians and allied professions, including degree, associate degree, diploma, and licensed practical nurses; technologists; technicians; and therapists; and others in the health care field."

The program will be offered initially to physicians, but eventually programs will be activated for nurses and other allied health personnel.

The Mississippi Postgraduate Institute in the Medical Sciences registered its first group of 20 family physicians this fall. Two of the eight scheduled one-week intensive refresher courses were completed in October.

The Institute was funded by a grant from the Regional Medical Program, approved at the national level in July. It was developed as a joint and equal partnership of the Mississippi State Medical Association and the University Medical Center. Long range plans call for a permanent Institute building on the Medical Center campus.

Dr. William O. Barnett, professor of surgery and chairman of the MSMA Council on Medical Education, is project coordinator. Dr. Barnett is also chairman of the professional education committee at UMC and continuing education coordinator for the Mississippi Regional Medical Program.

The program comprises 440 hours of study over four years and leads to a certificate of excellence in postgraduate education. Enrollment is limited to 20 for 1969 and another class of 20 will be accepted in 1970.

ORGANIZATION / Continued

Each participant will be assigned a faculty member as adviser who will help him develop a two-part course of study to be pursued over the four years. Institute members must take 30 hours of electives per year. Each participant must earn 15 hours per year in attendance at approved circuit courses and seminars and 15 hours per year at scientific sessions of national, state, and local organizations. This credit may also be earned for preparation and publishing of scientific exhibits at state, regional and national medical meetings.

Registrants will be expected to attend two one-week refresher courses at the Medical Center each year. No more than five physicians will be accepted in any of the eight courses since they involve extensive physician participation. If special circumstances arise, registrants may be permitted to vary the number of courses per year so long as the required total is achieved within four years.

There is no registration fee for the intensive refresher courses. Mississippi Regional Medical Program grant funds will reimburse applicants who live outside of Jackson for the cost of travel at the University rate of 7 cents per mile for one round trip and will also provide $16 per day toward the cost of lodging and subsistence.

The intensive refresher course schedule for the remainder of 1969-70 is: Gastroenterology, Nov. 3-7; Cancer Chemotherapy, Jan. 19-23, 1970; Radiology, Feb. 9-13; Nephrology, March 2-6; Neurological Diseases and Stroke, March 16-20; and Cardiology, March 16-20.

All courses will be similar in format to the three sessions on stroke which 14 physicians completed in the 1968-69 academic year. Registration will be limited to four classes of five physicians.

Institute participants and all other state physicians may attend any of eight circuit courses and select from a schedule of one to three-day seminars occurring at monthly intervals throughout the year and covering a variety of topics.

Credit may also be earned in Specialist of the Day sessions cooperatively offered by the medical school, Mississippi Regional Medical Program, and local medical staffs.

As set forth in the application for RMP funds, the program's "ultimate goal is to improve medical care for patients in this region by adding to or renewing the knowledge and skills of the health team. More effective utilization of health manpower is also expected to follow." The immediate objective is to use all available resources to put a model for postgraduate education into operation and to test the plan in action.

Jaycees Undertake Drug Program

The Mississippi Jaycees are initiating a new state project, Jaycee International Medical Supplies (J.I.M.S.). The new program is being coordinated with the Food and Drug Administration and the Mississippi State Medical Association.

Plans are to collect drug samples, excluding amphetamines and barbiturates, from doctors throughout the state. These will be shipped to Project Concern, Inc., P. O. Box 2468, San Diego, Calif. This organization, headed by Dr. James Turpin, maintains hospitals in Viet Nam and hospital ships in Hong Kong Harbor.

Physicians will be asked to contribute the drug samples they accumulate to this project. A member of the local Jaycee chapter will collect the drugs from the office nurses and they will be taken to Jackson for the Jaycee State Meeting. At this time the Mississippi Air National Guard will fly them to the San Diego headquarters of Project Concern, Inc. where they will be readied for shipment overseas.

Hospitals are also asked to contribute. Robert Lingle, Assistant Hospital Administrator of Singing River Hospital, will contact administrators throughout the state for discarded but repairable medical and surgical supplies.

By carrying out the plan as outlined, the drugs will be under the direct control of the local Jaycee representative until shipment.

Miss. Psychiatric Assn. to Meet

The Mississippi Psychiatric Association will hold its fall meeting on the 8th floor, University Hospital on November 22, 1969.

Guest speaker will be William Keller, M.D., chairman, department of psychiatric, University of Louisville.

Officers for the year are: George C. Hamilton, Jr., president; Wm. H. C. Dudley, Jr., President elect; and Wm. C. McQuinn, secretary-treasurer.

MSMA Exec Denies 'Moonshine Charge'

"Not me!"

This was the ungrammatical assertion of Executive Secretary Rowland B. Kennedy in response to ribbing over an October news story in the *Jackson Daily News*.

The story recounted how federal agents seized a moonshine still in Harrison County, arresting one Roland Kennedy, 24, and Pedro Davis, 35, both of Picayune. MSMA's Kennedy said it was the first time he had ever heard of another Rowland or Roland Kennedy.

"The closest parallel to my name was the Rev. Noland Kennedy who was pastor of the Clinton Baptist Church in the late 1940's," Executive Secretary Kennedy said. "I used to receive his copy of the *Baptist Record* occasionally, and he would get my *JAMA*."

Kennedy said that he had been ribbed unmercifully, receiving a dozen copies of the news story by mail, about the same number of telephone calls, and three orders for a gallon each of moonshine.

Additional Progress Marks Midpoint

Completion on schedule is virtually assured for the association's building addition as structural steel rises and the massive substructure is completed.

This was the announcement of Drs. Mal S. Riddell, Jr., of Winona, chairman of the Board of Trustees and building committee, and James L. Royals of Jackson, president.

At the midpoint in the 180 day contract with Priester Construction Co., general contractor, the architect, W. R. Bob Henry, A.I.A., of Jackson said that finish work had been completed on the foundations and substructure which houses a lower level and that steel erection was well underway.

"Masonry work will be begun as soon as we have the steel in place," Mr. Henry reported.

The wall structure will match the foundation in quality and durability with brick exterior, air cavity, cement block middle wall, thermal insulation, and interior walls, Mr. Henry said.

Although hindered by some supply problems and one period of bad weather, the project is proceeding as planned, Drs. Riddell and Royals said.

Also reported was an action of the Executive Committee of the Board of Trustees approving acquisition of needed office equipment for the addition. Previous conservations make possible cash purchase of the needed items, the committee said.

The report said that the original building will be repainted, and carpets and drapes will be replaced. These furnishings were installed in the building in 1956 when it was originally completed, and replacement was deferred in 1968 until the addition project was also completed.

Mr. Henry said that all rough electrical and plumbing work is substantially completed and that mechanical subcontractors would soon begin installation of air conditioning and heating ducts. The completed project will be heated and cooled in four zones for economy of operation, he added.





Concrete finishers swarm over top level of association building substructure, capping off major stage of construction. Right, vertical steel columns are in place as steel erection work begins. Full span I-beams will assure column-free interior with full roof and ceiling suspension.

Board Honors Air Guard Commander

The Board of Trustees honored Brig. Gen. George M. McWilliams of Jackson, deputy chief of staff for air of the Mississippi National Guard, for his leadership and service role in the Hurricane Camille disaster. Gen. McWilliams worked with the association in the movement of hospital and nursing home patients during the critical post-strike period.

The occasion was a luncheon during the recent meeting of the Board. Present also was Dr. C. D. Taylor, Jr., of Pass Christian, immediate past chairman of the Board and incumbent president of the staff at Memorial Hospital of Gulfport. Dr. Taylor filled a prominent role of leadership in caring for storm victims.

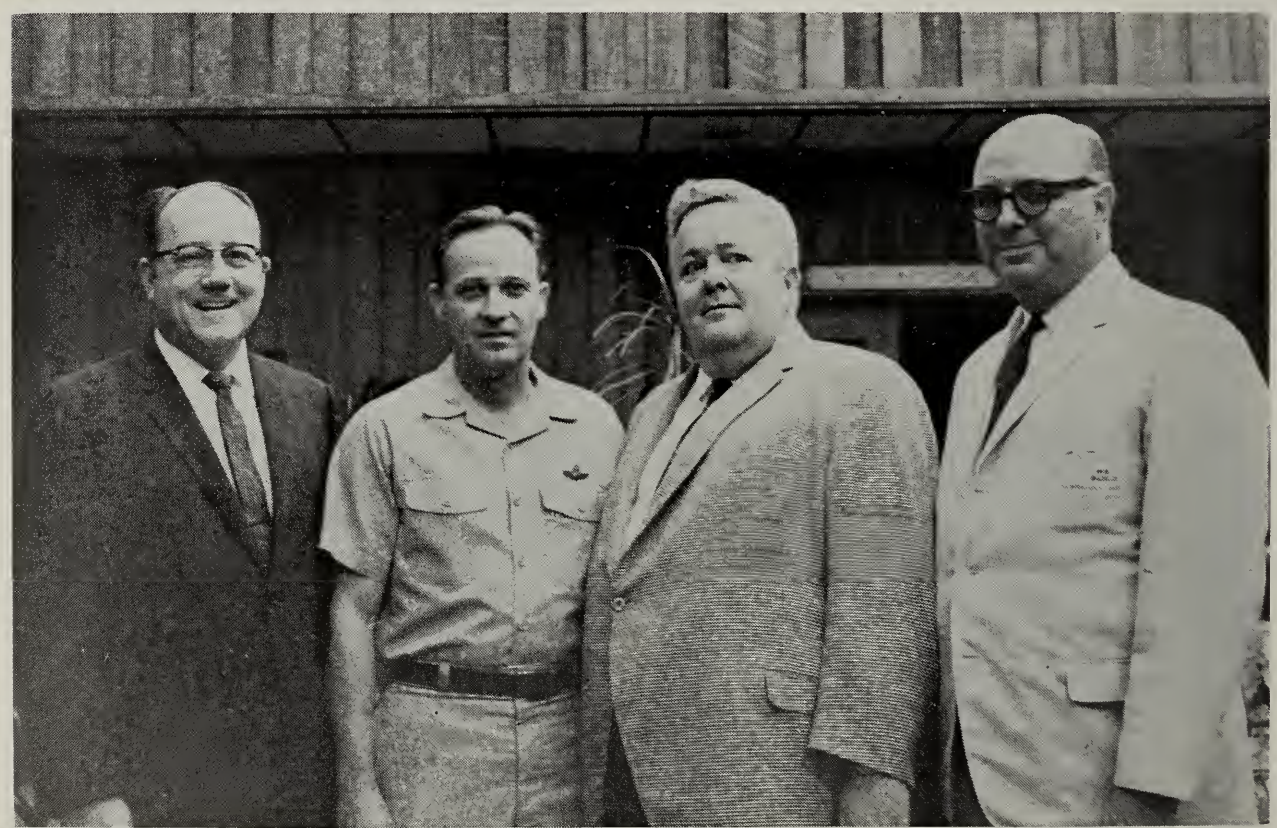
Drs. Mal S. Riddell, Jr., of Winona, Board chairman, and James L. Royals of Jackson, association president, praised Gen. McWilliams and the Air Guard team for effective service in medical air evacuation missions.

Dr. Royals said that "there is no way of measuring the saving and salvage of human life made possible by the efficient and timely Air Guard operations."

The Guard flew the giant C-124 Globemaster aircraft in as many as five missions daily following the hurricane. The largest single mission series was movement in one day of 118 patients from the Miramar Village Nursing Home at Pass Christian to hospitals at Meridian.

Gen. McWilliams said that the Guard's maximum effort reflected the team spirit among full-time professionals and the weekend warriors with the people and medical profession of the state. The much-decorated general is a combat veteran of World War II and Korea. He is a career air officer whose nomination for promotion to brigadier general by the President was confirmed last year by the U. S. Senate.

During the luncheon, Dr. Taylor reviewed the emergency medical service operations and advanced a number of recommendations for increasing effectiveness in major natural disasters.



Association leadership congratulates Brig. Gen. George M. McWilliams, second from left, on service to patients in air evacuation missions during the Coast hurricane disaster. From the left are Dr. James L. Royals, Gen. McWilliams, and Drs. Mal S. Riddel, Jr., and C. D. Taylor, Jr.

Dr. Lotterhos Is Named AAGP President-Elect

Dr. William E. Lotterhos of Jackson was named president-elect of the American Academy of General Practice at the organization's annual assembly in Philadelphia, Pa. Dr. Lotterhos, in his capacity as chairman of the AAGP's Board of Directors, recently played a key role in the establishment of the twentieth specialty, that of family practice.



Dr. Lotterhos

Dr. Lotterhos has a long history of interest in the family practitioner and the AAGP. He was the first Mississippian to be named a director of the AAGP at the 1966 Boston convention after serving in a number of key posts. In 1967 he was named chairman of the Board of Directors. He served with distinction on the special committee to develop criteria for the core curriculum for family practice residencies. and he has worked with the Council on Medical Education and the Advisory Board to the Medical Specialties on the certifying board which has been approved.

In 1954 Dr. Lotterhos was chairman of the national publications committee, parent body of the Academy's Journal, *GP*. He also was a member of the AAGP Congress of Delegates.

Not all of the Jackson physician's work on behalf of the family practitioner has been on the national level. He is a past president of the Mississippi Academy and served as chairman of the section on general practice at the 94th MSMA annual session in 1962.

Other offices Dr. Lotterhos has held include vice chairman and chairman of the Section on General Practice, AMA, from 1964-present; president of the Jackson Council on Alcoholism, 1959; and legislative keyman for Mississippi, AMA Council on Legislative Activities, 1958-62.

The Jackson physician, a native of Crystal Springs, is the senior member of the Family Medical Center in Jackson. He received his B.S. degree from the University of Mississippi, and M.D. degree from the University of Tennessee. He did his internship at the Mississippi Baptist Hospital in Jackson and took postgraduate training at Methodist Hospital in Memphis.

The father of five children, Dr. Lotterhos is married to the former Elizabeth Teat. He has been engaged in private practice in Jackson since 1947. Dr. Lotterhos served during World War II in the U. S. Army Medical Corps. He holds the Bronze Star, Purple Heart, Combat Medics Badge, Legion of Merit, and Italian Military Cross of Valor.

Dr. Lotterhos has membership in the following professional societies: AAGP, AMA, MSMA, American Geriatric Society (fellow), and Central Medical Society. His fraternal affiliations include Kappa Alpha, Phi Chi, and ODK.

Also a civic leader, this doctor has served in a number of key community posts such as Mississippi State Nurses Board of Examiners; chairman, Medical and Dental Affairs Committee, Jackson Chamber of Commerce, 1962; and president of the Medical Alumni Chapter, Ole Miss Alumni Association, 1963.

He is currently a member of Council Andrew Jackson District of Boy Scouts, as medical adviser. Dr. Lotterhos is on the consulting staff of Mississippi Baptist Hospital, St. Dominic's, Hinds General, and Doctors Hospital in Jackson. He was chief of staff at Baptist in 1956.

In his state medical association, Dr. Lotterhos has been active in a variety of areas. He is currently speaker of the MSMA House of Delegates (1968-70), having also served as vice speaker and secretary-treasurer. He has also held the posts of chairman of Council on Legislation (1954-62); chairman of Council on Scientific Assembly (1958-61); chairman of Credentials Committee (1959-62); chairman of Medical Practices, reference committee; and chairman of Public Policy and Legislation Committee (1956-58).

Other accomplishments include two terms on the American Medical Association Council on Scientific Assembly, secretary and president of Central Medical Society, and a medical member of the State Medicare Review Board.

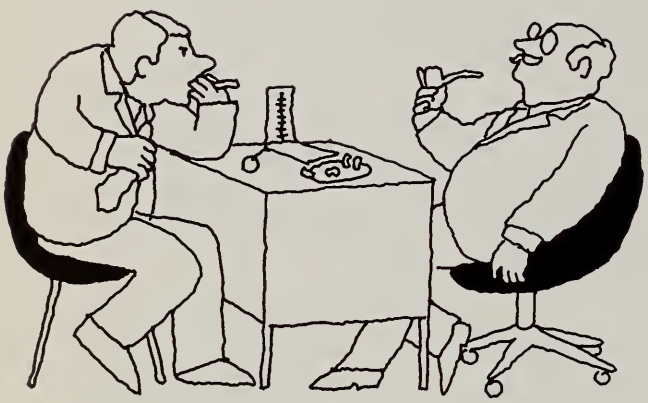
The association's officers have congratulated Dr. Lotterhos on this latest achievement.

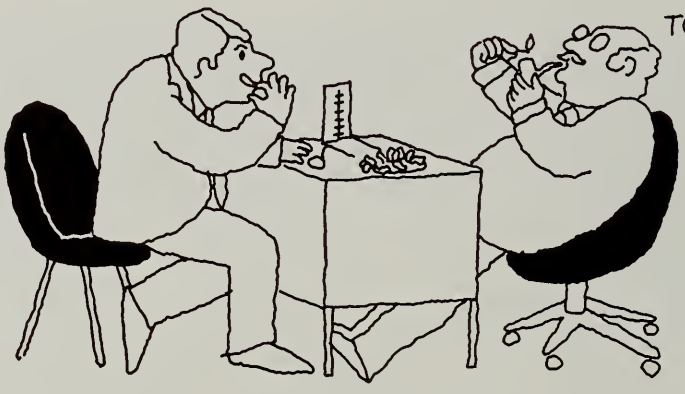
MSBH Attacks German Measles

The death knell is sounding in Mississippi for rubella—one of the major causes of birth defects.

At press time the guidelines for giving Rubella Virus Vaccine, Live, through the health departments had been drafted and the Preventable Dis-

The Apprehensive Hypertensive



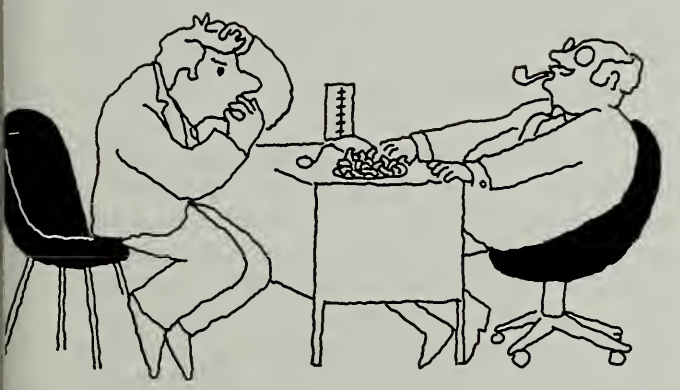


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WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.



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rticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones iliary colic may be precipitated). Bronchial asthma may occur in sceptible patients. *Adverse Reactions:* The drug is generally well lerated. The most frequent side effects are nausea, gastric irritation, miting, diarrhea, constipation, muscle cramps, headache, dizziness id acute gout. Other potential side effects include angina pectoris, xiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglymia and glycosuria, hyperuricemia, lassitude, restlessness, transient yopia, impotence or dysuria, orthostatic hypotension which may be tentiated when chlorthalidone is combined with alcohol, barbiturates narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytonia, agranulocytosis, nasal stuffiness, increased gastric secretions, ghtmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic rophy and glaucoma, and pruritus. Eruptions and/or flushing of the in, a reversible paralysis agitans-like syndrome, blurred vision, conctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

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ease Control Division was eagerly awaiting the State Board of Health's first allotment of the new vaccine.

PDC Director Durward Blakey says the vaccination program will be directed first to children of both sexes in kindergarten and first grade (ages 5 and 6 years). Then as rapidly as possible, the program will be extended to include second-and-third-graders (ages 7 and 8 years), and insofar as practicable, such preschool groups as Head Start and Day Care children. These children constitute the "First Priority Group."

As soon as large supplies of vaccine become available, Dr. Blakey says, the vaccination program will be extended to the "Second Priority Group"—children in grades 4, 5 and 6 (ages 9, 10 and 11 years).

"Ultimately, either adequate supply of vaccine or adequate coverage to the first two priority groups will allow establishing a basic, maintenance program," states Dr. Blakey. "This will be done by vaccinating any remaining unprotected children in the preschool group and incorporating rubella vaccination in the routine well-baby program."

Since a severe rubella epidemic is predicted for 1970-71, Dr. Blakey say maximum use will be made of whatever vaccine supplies are available to the State Board of Health.

The Public Health Laboratory is now providing a service to private physicians and health departments to aid in the attack on rubella. It is the rubella hemagglutination-inhibition test.

Usually referred to as the HI test, this rubella serology may be secured from the Laboratory for five purposes: to confirm congenital rubella; to evaluate risk for pregnant women with rubella-like illness; to evaluate immune status of pregnant women exposed to rubella; to establish etiology of a localized outbreak of rash illness; to evaluate rubella complications.

The Laboratory, in cooperation with The National Foundation, is offering the HI test because it is not widely available in Mississippi, said Laoratory Director Richard H. Andrews.

Two Scholarship Recipients Named

Two men have been named as recipients of the first H. Maurice Little MH-MR Memorial Scholarship Award by the Mississippi Jaycees. The $2,000 stipends were awarded to Jon E. Williams, of McComb and Billy R. Fox, of Clinton. They will be required to return to Mississippi for one year of work in the mental health and retardation fields.

Williams is a cum laude graduate of Millsaps College, and studied at the University of Cologne in West Germany as a Fulbright Scholar. He received a Bachelor of Divinity from Union Theological Seminary in New York City, and has received his M.S. from the University of Maryland, majoring in clinical psychology. He is presently a candidate for the Ph.D. degree in clinical psychology at the University of Maryland. After graduation he plans to work in Mississippi in community mental health service, research and training.

Fox is a graduate of the University of Southern Mississippi and received a Masters in Education at Mississippi College. He has received further study at Mississippi State University, and has studied at Harvard Medical School for six months under a Psychiatric Rehabilitation Internship Program. He is presently a counselor with the Vocational Rehabilitation Division of the Mississippi State Department of Education, and will work toward his Ph.D. at the University of Southern Mississippi.

MSBH Praises State Milk Industry

Mississippi's milk industry was praised by State Board of Health officials for its response to emergency needs along the Gulf Coast left by Hurricane Camille.

"The response was prompt and effective," said Dr. H. B. Cottrell, state health officer, "and the milk industry deserves the highest praise for such a service."

Clinton Van Devender, supervisor of the milk sanitation control program for the State Board of Health, said the milk industry "was eager and anxious to help in the crisis."

He said he was in touch with the milk industry as soon as the hurricane hit, and he added that spokesmen for the industry were calling him to see how they could be of service.

Van Devender said various milk processors in different sections of the state sent not only milk but drinking water, ice and dry ice to the stricken area.

"They checked with us to see where the milk was most needed," said Van Devender, "and they had the milk on the way to the coast in a matter of an hour or so."

He said the milk processors shipped hundreds of thousands of half gallons of packaged milk and packaged water and also delivered milk and water in stainless steel tank trucks.

Blue Plan Realigns Top Management

A major realignment of management has been instituted in the top executive echelons of the Mississippi Hospital and Medical Service, the state's Blue Cross-Blue Shield plan. This was the announcement of Dr. J. C. Woosley of Jackson, president of the organization.

The management changes involve boosts in the president's office in support of corporate affairs and internal operations with three working divisions under an executive vice president and general manager.

Dr. Woosley said that "the effective dates of these changes will be gradually spread over the next two months to allow for the orderly transfer of responsibilities for each officer concerned.

"We look forward to an improved organizational efficiency under this rearrangement, and we expect it to make a significant improvement in the accomplishments of the plan," Dr. Woosley added.

Named to new or reassigned top posts are:

—Eustice G. Raines, executive vice president for corporate affairs, and Neal W. Cirlot, promoted to administrative assistant, both in the office of the president.

—George W. Butler, promoted to executive vice president and general manager, responsible for operations and chief of three working divisions.

—William G. Shackelford, vice president, reassigned to head the marketing division and assisted by George P. Lane and Butelle Graham, vice presidents.

—W. C. Mosley, vice president, assigned as chief of the hospital (Blue Cross) and professional (Blue Shield) affairs division.

—James H. Reed, vice president, named to head the administrative services division, assisted by Raymond J. Zasoski and Gaddy V. Temple, vice presidents.



Watching Blue Cross-Blue Shield president, Dr. J. C. Woosley, sign the new executive realignment into effect are the six men involved. Assigned to new positions in the Mississippi Hospital and Medical Service organization are, from left to right, Eustice G. Raines, W. G. Shackelford, Neal W. Cirlot, Dr. Woosley (seated), James H. Reed, George W. Butler, and W. Chandler Mosley.

State Journal Leaders Meet at Chicago



Dr. Lawrence W. Long of Jackson, chairman of the association's Committee on Publications, confers with Dr. Frank B. Ramsey of Indianapolis, president of the State Medical Journal group, right, during the recent biennial conference of state journal leaders at Chicago.

New Therapy Aids Multiple Sclerosis

New hope for better control of multiple sclerosis—one of the most disabling and, presently, incurable inflammatory diseases—was offered in a scientific exhibit at the annual meeting of the American Academy of General Practice.

Dr. George J. Boines of Wilmington, Delaware, reported that 82 per cent of 500 patients showed good to excellent improvement when intrathecally injected methylprednisolone acetate (Depo-Medrol, Upjohn), a steroid drug widely used in the treatment of rheumatoid arthritis, is combined with the management of the multiple sclerosis patient.

Remission of the disease began within 48 hours after the first intrathecal injection, he said. "Usually a plateau of improvement is attained after the first series of six injections, but a booster may be necessary three, six or twelve months later."

Use of the drug was part of a course of treatment which included physical therapy and exercise. "This regimen gives the patient physical and mental comfort, retards the progress of the disease, reduces disability and keeps the patients active and hopeful," he said.

Dr. Boines explained that some unknown factor in multiple sclerosis blocks the transmission of nerve impulses to the muscles—producing such symptoms as weakness, incoordination, jerking movements, slurred speech and emotional imbalance. However, "intrathecal methylprednisolone acetate tends to neutralize this factor and allow the release of inhibited nerve impulses to the muscle." Intrathecal injection is the only effective method of administration of the drug in multiple sclerosis patients.

He added that remission of the disease is probably due to the medication's activity in suppressing inflammation and hyperimmunologic responses of the central nervous system.

Cooley Keynotes Blood Bank Meet

Dr. Denton A. Cooley, surgeon who has performed the most human heart transplant operations, will deliver the keynote address at the 22nd annual meeting of the American Association of Blood Banks in Houston Nov. 16-20.

More than 2,500 physicians, technologists and administrators are expected to attend the sessions at the Shamrock Hilton Hotel. Dr. Frank C. Coleman, Tampa, Florida, is president and Dr. Enold H. Dahlquist, Jr., Providence, Rhode Island, is president-elect of the association.

The scientific program will include papers on advances in the use of platelets, frozen blood, the discovery of new blood sub-types, use of adenine in blood preservation and a symposium on antigen-antibody reactions. Dr. Nevin C. Hughes-Jones of St. Mary's Hospital Medical School, London, will be a participant.

Administrative section papers will include reports on computerization of donor records, advances in the production and use of blood components, transfusion practices to conserve blood and the characteristics of platelet donors.

Dr. Emanuel Hackel of East Lansing, Michigan, professor and chairman of the department of natural science, Michigan State University, will be the Emily Cooley Memorial Lecturer and Awardee at a preconvention seminar on basic

genetics Monday, November 17. Dr. Douglas Huestis of the University of Arizona will preside.

Participants will include Dr. Fred H. Allen, Jr., Miss Julia Mann and Dr. James German, all of New York; Dr. Robert R. Eggen, Spokane, Washington; Peter Issitt, Oxnard, California; Misses R. Pauline Schmidt, Miami; Jane Swanson, Minneapolis; and Marjory Stroup, Raritan, New Jersey.

Activities will start Sunday, Nov. 16, with technical workshops on quality control in blood banking and problems relating to transfusion. These will be directed by Dr. L. Ruth Guy of Dallas.

It will be the association's first meeting in Texas since its organization at Dallas in 1947. The hospital and community blood banks that founded the organization had rushed blood and plasma earlier that year to Texas City when a ship loaded with chemicals blew up injuring several thousand people.

With nearly 5,000 members in all states and 35 foreign countries, the association is the largest organization in the world devoted solely to blood banking. Its 1,219 institutional members used 5,008,170 units of blood and blood derivatives last year. It has established standards for blood banks and a voluntary inspection and accreditation system.

It also has regional laboratories for identifying rare blood types, a central file for rare donors in Chicago and a national clearinghouse system for the exchange of blood and blood credits which permits blood given locally to be credited to a patient in a distant city.

PMA Foundation Offers Faculty Awards

The Pharmaceutical Manufacturers Association Foundation has announced it will offer faculty development awards for 1970 to help meet manpower needs in clinical pharmacology.

Thomas E. Hanrahan, Executive Director of the Foundation, said announcements describing the award program have been mailed to about 100 colleges and universities. The purpose of the award program, which was inaugurated in 1966, is to stimulate teaching, training, and research in the field of clinical pharmacology.

Medical schools are given the opportunity to suggest candidates at the junior faculty level who indicate a "strong determination for a full-time career in clinical pharmacology, either in a medical school, or related institution, or in the pharmaceutical industry."

The two-year awards include variable salary features and other benefits. The deadline for applications is Nov. 1.

Hanrahan said recipients will be selected by the Foundation's Board of Directors, based upon recommendations from an advisory committee composed of individuals from the pharmaceutical industry, the academic community, and the government.

Awards for 1969 went to Asst. Prof. Vincent S. Aoki, M.D., of the University of Iowa; Asst. Prof. Lester F. Soyka, M.D., Stanford University; Lecturer Pate D. Thomson, M.D., University of California, and Asst. Prof. Stanley C. Ushinski, M.D.,University of Pittsburgh.

AAA Presents Feb. Postgraduate Course

The American Academy of Allergy will present a two-day postgraduate course in connection with its 26th annual meeting, Feb. 14-18, 1970. This meeting will be held at the Jung Hotel in New Orleans.

The postgraduate program offers subjects of timely interest in allergy, immunology and related fields. The opening session on Saturday morning, Feb. 14, will be devoted to *Pulmonary Diseases and Asthma,* the afternoon session pertains to *Developments in Medicine Relating to Allergy*.

On Sunday, Feb. 15, *Clinical Immunology* will be discussed during the morning session, and in the afternoon, a session on *Organ Transplantation* will be featured. An outstanding faculty has been invited to present this continuing education program.

The annual meeting scientific sessions will convene Monday, Feb. 16, ending Wednesday, Feb. 18. The program for these three days will highlight presentations of new research in allergy and related fields.

Both meetings are open to all physicians and others interested in attending.

Details of the program can be obtained by writing to the American Academy of Allergy Executive Office, 756 North Milwaukee Street, Milwaukee, Wisconsin 53202.

Academy Issues Poisoning Guidelines

If childhood lead poisoning is to be eliminated in the United States, the most important consideration should be the elimination or proper rehabilitation of substandard housing throughout the Nation's cities, according to the American Academy of Pediatrics.

In a statement appearing in a recent issue of *Pediatrics,* the AAP Subcommittee on Accidental Poisoning emphasizes that lead poisoning occurs most frequently in the United States in children one to five years of age living in deteriorated, pre-World War II urban housing. Acute toxic cases occur most frequently in the summer months.

"Prospective surveys in various cities indicate that 10 to 25 per cent of such children have absorbed potentially dangerous quantities of lead, and that two to five per cent have clinical symptoms compatible with those of acute intoxication," the statement points out.

The Academy further emphasizes that lead poisoning in childhood must be approached as a chronic disease requiring comprehensive, long-term, medical and social management of the child and his family throughout the preschool years.

"This is because of the combination of poor housing containing lead paints, childhood pica (compulsive ingestion of certain nonfood items including paint chips), and personal-social deprivation," the AAP statement stresses.

The Academy further warns that new sources of lead, such as general contamination of the environment from industrial and motor car exhausts, must also be considered when studying the causes of lead poisoning.

Discussing pica, the habitual, purposeful, and compulsive search for and ingestion of such nonfood items as clay, plaster, and paint chips, the statement indicates that the beginning of this condition occurs at about one year of age. The habit tends to disappear between three and five years of age.

"The child with pica often stimulates behavior in younger siblings," the AAP points out. "As many as 50 per cent of mothers of children with pica also have pica themselves."

To diagnose lead poisoning in time, early identification of the high-risk child, the high-risk parent, and the high-risk dwelling is essential, the AAP subcommittee emphasizes.

A toddler with exaggerated oral activity; a mother with inadequate resources to cope with her family's needs, or a neglected housing unit with lead flakes within reach of a small child's grasp, can indicate possible lead poisoning.

Clinical indications may include a child's loss of appetite, lack of interest in play, loss of alertness, and hyperirritability.

"Immediate and permanent separation of the child from the sources of lead in his environment is essential for any child with an excessive body burden of lead," the Academy statement indicates.

"Long term care is essential and, in many ways, is both the most difficult and the most important aspect of treatment," the statement stresses "The first precept is: no child ever returns to a leaded house."

"The development of health programs in the poverty areas of most of the large cities of the United States offers an excellent mechanism for the institution of mass procedures for early recognition and prevention of childhood lead intoxication," the Academy concludes.

"To be effective, these programs must be supported by a local health department with appropriate personnel and laboratory at its disposal."

Alcohol Education Grant Renewed

A model program of alcohol education has moved into its fifth year in two Mississippi cities with the renewal of a research grant to Mississippi State University. The project, considered the only one of its kind in the nation, is being conducted in Clarksdale and Tupelo under financing from the National Institute of Mental Health by MSU's Department of Sociology and Anthropology. The latest grant is for $75,980.

Begun four years ago with a two-year period of research and planning, the comprehensive, community-oriented program of alcohol education has been in actual operation for two years now. In each of the two cities, objective instruction in the use of alcohol has been incorporated into regular subjects in grades seven through twelve, while an adult-information program has been carried on with ministerial groups, anti-poverty agencies, civic groups and other organizations. "The program will demonstrate that it is possible to saturate a community with information about beverage alcohol and alcoholism, thereby creating an understanding of the disease," according to Dr. Gerald Globetti, associate professor of sociology and director of the project.

Alabama Reynolds Library Publishes Pasteur Letters

A collection of original documents and letters written by Louis Pasteur and his young colleague, Louis Thuillier, entitled *Correspondence of Pasteur and Thuillier,* has been published by the University of Alabama Press. Seventeen of the Pasteur letters are owned by the University of Alabama Medical Center's Reynolds Historical Library; the other documents and letters were supplied by the Pasteur Institute in Paris.

The letters were translated and edited by Dr. Robert Frank, head of the Research Department at the Institute Dentair and Professeur Agrégé of Stomatology, Faculty of Medicine, University of Strasbourg, Strasbourg, France, and visiting professor of dentistry at the University of Alabama School of Dentistry. Dr. Frank's co-editor, Mademoiselle Denise Wrotnowska, curator of the Pasteur Museum, also contributed an introductory essay.

The letters all relate to Pasteur's work with Thuillier on two diseases of animals—anthrax (a disease of cattle and sheep) and swine fever. Only one of the letters was published previously, by the great scientist's grandson, Professor Pasteur Vallery-Radot, the foremost authority on Pasteur.

Officials of the Medical Center and Dr. Frank have long been interested in translating and publishing the Pasteur documents which were part of the collection given to the Medical Center by the late Dr. Lawrence Reynolds. But they had to first locate Thuillier's replies to the letters, which would make them valuable as a historical vignette, and to secure permission to publish them along with Pasteur's letters.

The replies were eventually located at the museum of the Pasteur Institute, and through the persuasive efforts of Mademoiselle Wrotnowska, the director of the Institute, Doctor Pierre Mercier, gave permission to publish the replies and also included another 44 pieces of correspondence between Pasteur and Thuillier, heretofore unpublished. The result will be not only a historically significant record of the scientist's early efforts to establish the effectiveness of vaccination, but a very fine characterization of young Thuillier and evidence of Pasteur's regard for him.

The book was scheduled to be released June 11, 1969. Ceremonies marking the official release of the book were held at the Pasteur Institute in Paris. Dr. Joseph F. Volker, executive vice president, University of Alabama in Birmingham, and Dr. S. Richardson Hill, Jr. UAB vice president for health affairs, represented the University. The French delegation was led by Professor Georges Champetier, President du Conseil d'Administration de l' Institut Pasteur.

The correspondence dates back to the early 1880's, when Pasteur sent Thuillier to Hungary to verify work on Anthrax vaccination established by Pasteur, in Pouilly le Fort, France. The disease is an infectious malady characterized by the formation of hard swelling or ulcers at the point of inoculation and by symptoms of collapse. Pasteur had isolated the bacillus and postulated the concept of weakening the virulence of the bacilli in order to provide immunity to the disease through vaccination. He said the disease was responsible for the death of 900,000 animals in the United States in 1879.

This group of letters from Pasteur is in the Reynolds collection; Thuillier's answers were provided by the Pasteur Institute. The letters are an entertaining commentary on Pasteur's private controversy with Koch. Later, Koch was to accept Pasteur's theories and to adopt them. Meanwhile, Thuillier, in the role of "observer," was reporting to his master on Koch's work. In one missive, he discloses to Pasteur that Koch had discovered the tuberculosis bacillus—a piece of information as yet unannounced to the world.

The second set of letters deals with experimentation on swine fever, conducted in the south of France at Bollene. The work here was done in collaboration with a veternarian, Maucuer, who became fast friends with both Pasteur and Thuillier. Correspondence between Pasteur and Thuillier and also between Maucuer and Thuillier (the latter provided by the Pasteur Institute) are included in the translations.

A short time later, Thuillier became an associate of Koch on a scientific venture in Cairo. There he contracted cholera and died in 1883 at the age of 27. In one of Pasteur's letters to Maucuer, the French scientist expresses his great affection for Thuillier and mourns his death as a great loss.

The book contains a foreword by Pasteur Vallery-Radot who is a member of the distinguished Academie Francaise, the French government's renowned authority on French semantics. Photographs of Thuillier which have never been published, and photocopies of five of the most important documents, four cables and one letter, are also included.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 30-Dec. 3, 1969, Denver, Colo.; Annual Convention, June 21-25, 1970, Chicago. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 63rd Annual Meeting, Nov. 10-13, 1969, Atlanta, Ga. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 102nd Annual Session, May 11-14, 1970, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. James S. Poole, Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Joseph B. Miller, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 1237, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Mary's Restaurant, Hernando, Malcolm D. Baxter, Jr., Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. Edward Pennington, Ackerman, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. M. Howell, 139 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

Singing River Medical Society, Third Monday January, March, June, September, and December. Donald E. Dore, Singing River Hospital, Pascagoula, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. W. B. White, 1007 Jefferson Street, Laurel, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, the Street Clinic, Vicksburg, Secretary.

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JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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CONTENTS

ORIGINAL PAPERS

The Zollinger-Ellison Syndrome: With Report of Illustrative Case **535** John J. Kluck, Jr., M.D., and James D. Hardy, M.D.

Experiences with Electrical Cardioversion in an Outpatient Clinic **542** John H. Woodbridge, M.D.

SPECIAL ARTICLES

Clinicopathological Conference XCV **545** Mississippi Baptist Hospital, Jackson

Radiologic Seminar XC: Intracranial Arteriovenous Malformations **551** Bernard Carr, M.D.

EDITORIALS

Gnats and Camels: A Matter of Reasonableness **555** The Frost on Fees

Priceless Service by Meridian Physicians **557** Above and Beyond

Tougher Taxes for American Medicine **557** Corporate Necrosis?

CHAMPUS: An M.D.-Managed Care Plan **558** DOD Decision

On Becoming 10 Years of Age **559** Journal Grows Up

THIS MONTH

The President Speaking **554** Supply and Demand

Medical Organization **565** Ole Miss Medical Alumni House Nears Completion on Medical Center Campus

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SFK Foundation Is A Charitable Trust

Projects dealing with the rapidly developing urban crisis were given a high priority in 1968 by the Smith Kline & French Foundation which contributed $908,970 for charitable, educational and scientific purposes.

The Foundation is a charitable trust established in 1952 by Smith Kline & French Laboratories, Philadelphia manufacturer of prescription medicines and other health-related products. Its total contributions have been $11,010,766.

Last year approximately one-half of the Foundation's contributions were for educational purposes. Altogether, grants designated for public charity and community improvement projects, and for education constituted 90 per cent of the Foundation's total contributions. The remaining grants were made to promote mental health, to match employee gifts and for a few miscellaneous purposes.

Funds for public charity and community improvement totaled $346,806. The largest grant, $137,820, was made to Philadelphia's United Fund.

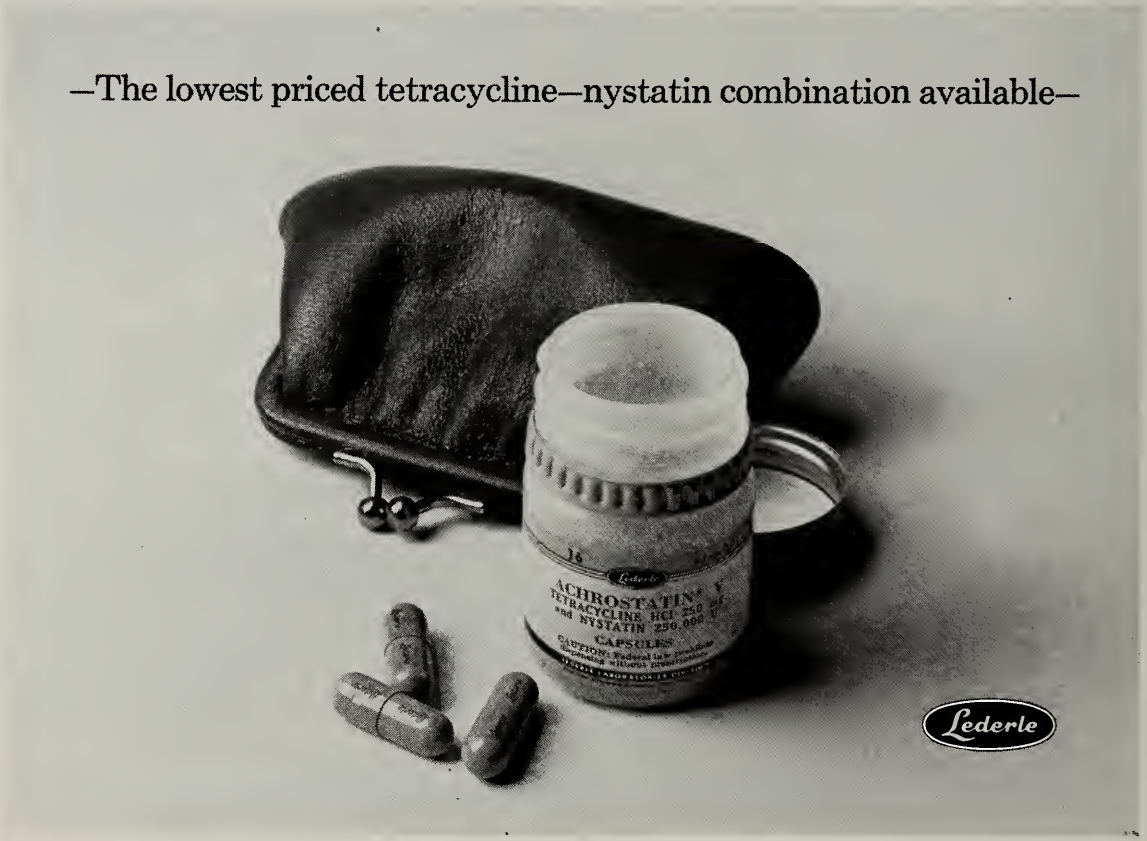
A pledge of $44,000 went to the Greater Philadelphia Foundation for a Black Coalition minority youth program, a project that grew out of a meeting between leaders of both the white and black communities. Philadelphia business pledged $1 million to support Coalition projects, and $30,800 was paid during the year toward the Foundation's pledge. The money was used to help the hard-core unemployed and to improve housing, education and health services in the inner-city.

Other groups working on inner-city problems also received grants, including the Urban Coalition which was given the largest sum, $25,000.

Grants amounting to $78,866 were made to eight hospitals in the Philadelphia area for building, expansion or improvement programs. This total includes a $25,000 payment on a $100,000 pledge to the new Children's Hospital-Philadelphia Child Guidance Clinic-Oakbourne Hospital complex.

The Foundation supported cultural activities in Philadelphia in the amount of $35,737. One of the grants, a $10,000 contribution to the Philadelphia Museum of Art, will be used to restore and preserve the Thomas Eakins House in the Spring Garden area near SK&F headquarters. Another was a pledge to the Museum of $21,000 payable over three years toward enlarging the *Ars Medica* collection of prints on medical subjects.

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The Foundation gave more than $345,000 to support educational projects and programs in medicine and biomedical sciences.

Sixteen unrestricted grants totaling $88,500 were made to newly appointed educators in medicine, pharmacy and mental health. These grants ranged from $1,000 to $10,000 and generally were used to implement projects for which funds were not otherwise available.

Support to medical school programs in clinical pharmacology continued. Harvard Medical School received $50,000, the last payment on a grant of $150,000, and the University of Pennsylvania School of Medicine received $15,000, the last payment on a $45,000 grant. Seven pharmacy schools received funds totaling $36,700.

Contributions for mental health programs totaled $54,100. The largest amount, $15,000, went to Horizon House's new psychiatric rehabilitation center in Philadelphia. This latest grant brings the Foundation's total gifts to Horizon House to $75,750.

Miscellaneous grants totaling $64,844 included an unrestricted grant of $10,000 to the recently created Leonard Davis Institute of Health Economics of the University of Pennsylvania. The Institute studies the economic and social aspects of health care and health care coverage.

In matching employee gifts to educational institutions and hospitals, the Foundation contributed $95,160 to 173 institutions of higher learning, 70 secondary schools and 36 hospitals.

Nursing League Conducts Study

A national study on the costs of nursing education and students' sources for financing preparation to become registered nurses is being conducted by the National League for Nursing, New York, under a grant of $60,917 from the Division of Nursing, U. S. Public Health Service.

Primary purpose of the study is to collect information which will help formulate federal policies for financial assistance to nursing students such as scholarships and loans.

Questionnaires have been sent to more than 15,000 students in 134 diploma, associate degree, and baccalaureate degree programs in nursing selected in a random sampling throughout the country. This is approximately 15 per cent of the national nursing school student body.

The study is an NLN Research and Development project. Hani Raphael Saigh, former lecturer in the department of economics, Hunter College, New York, is project director.

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Vt. Pediatrician Is AAP President-Elect

Robert James McKay, Jr., M.D., F.A.A.P., professor and chairman, department of pediatrics, University of Vermont College of Medicine, has been elected vice-president and president-elect of the American Academy of Pediatrics. The 10,800 member Academy is the Pan-American association of physicians certified in the care of infants, children and adolescents.

Dr. McKay was elected at the Academy's business meeting held during the AAP's 38th annual session in the Palmer House Hotel. He will be installed president of the AAP during its 1970 annual meeting in San Francisco, Calif.

Dr. McKay was born in New York City on Oct. 8, 1917. He received his A.B. degree from Princeton University in 1939, and his M.D. degree from Harvard Medical School in 1943.

Dr. McKay interned at Babies Hospital of Columbia-Presbyterian Medical Center from 1943-44 and became an assistant resident there in 1947. He was named chief medical resident at the Children's Hospital Medical Center in Boston, Mass., in 1948. Dr. McKay was a Milton Fellow in Pharmacology at Harvard Medical School and a Fellow in Pediatrics, Children's Hospital Medical Center in 1949.

While in the military service from 1944-46, Dr. McKay organized and directed the first community medical dispensary for occupational troops and their families in Bad Nauheim, Germany.

Dr. McKay was appointed assistant professor of pediatrics at the University of Vermont College of Medicine in 1950. He became chairman of the department of pediatrics at Vermont College in 1951, a post he still holds. Dr. McKay became associate professor of pediatrics at the University of Vermont College of Medicine in 1953, and moved up to full professorship in 1955.

He served as a Fulbright lecturer at the department of pediatrics at the University of Groningen, Netherlands in 1960.

Dr. McKay is a member of several professional societies including the American Medical Association, New England Pediatric Society where he served as president from 1965-66, the Society for Pediatric Research, and the American Pediatric Society.

Dr. McKay is trustee for the Vermont Tuberculosis and Health Association, chairman of the University of Vermont College of Medicine In-

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or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

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ternship Advisory Committee, senior pediatric consultant, Vermont State Health Department, and chairman of the Medical Advisory Board of Vermont Association for the Crippled. He was president of the Vermont Tuberculosis and Health Association from 1955-57.

He, his wife and four children reside in Williston, Vt.

U.S. Pharmacopeia Issues Stamp Appeal

The United States Pharmacopeial Convention has issued a plea for a commemorative stamp honoring the profession of pharmacy.

In 1970 the United States Pharmacopeia will be celebrating its 150th anniversary. Organizations old enough to celebrate their sesquicentennial anniversary are rare in America and rarer still are those that can truthfully lay claim to as illustrious a record as the United States Pharmacopeia, a record in which pharmacists have played a major role for over a century. The U.S.P. is the world's oldest continuously revised pharmacopeia.

The United States Pharmacopeial Convention is the only national organization in America representing both the professions of pharmacy and medicine. Its members include delegates from each state and national medical and pharmaceutical organization and each accredited school of medicine and pharmacy. Representation is also granted to national organizations of chemists and to certain departments of the federal government. Thus the U.S.P.C. is an agent of the two professions, medicine and pharmacy, and is the voice of the professions to the producers and the regulators of drugs.

The U.S.P. is a legally recognized compendium of standards for drugs, and includes assays and tests for the determination of strength, quality and purity. Standards of quality, purity, and strength established by the Pharmacopeia are enforced by the federal Food and Drug Administration, thereby making this an outstanding and highly successful model of cooperation between the government, the professions, and industry.

With this significant anniversary occasion and organized support from medicine and pharmacy, the U.S.P. commemorative stamp should become a reality.

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Switchboards, Traffic Lights Aid Patients

Two innovations in the form of telephone company and city traffic division hardware are new therapeutic aids for the handicapped at Spain Rehabilitation Center, UAB Medical Center. A telephone switchboard has taken its place beside a working-model traffic light at the Center.

Both instruments were built and donated to the Center by members of Telephone Pioneers of America, retired telephone company employees engaged in community service.

Dr. Samuel Stover, assistant professor both in the Department of Pediatrics and in the Department of Physical Medicine and Rehabilitation, Medical College of Alabama, explained how the seemingly unrelated machines are used. "To most individuals, coordinating a sound with a simple response and putting that response into action with a bodily movement, is a relatively simple task. But to the brain-damaged patient it may be tremendously difficult. Through the normally routine process of learning how to operate a switchboard the therapist can work with the patient on several different levels."

Dr. Stover said the exercises associated with operating a switchboard may aid in teaching organization of thinking, hand-eye-body coordination, and responsibility for an assigned task. The system may also be used to encourage communication of some handicapped patients who are reluctant to try to express themselves when they know others have difficulty understanding them.

The model traffic light system is another therapeutic tool at Spain Rehabilitation Center, operating on a concept similar to that of the switchboard. It is an effective aid in teaching signal and color recognition to the handicapped.

Dr. Stover explained that the new teaching aids at Spain are only two examples of the educational gadgets being used in therapy today. It is up to the therapist himself to determine which ones will be most helpful in a particular case.

AMA Urges Congress to Adopt "Medicredit"

An American Medical Association spokesman has urged the House Ways and Means Committee to consider adoption of its voluntary national health insurance plan, which it terms "Medicredit."

According to Dr. Russell B. Roth, speaker of AMA's House of Delegates and practicing physician in Erie, Pa., "Medicredit" would not affect the present Medicare program for those 65 and older.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

December 1969

Dear Doctor:

The 1970 California Relative Value Index, first update since 1964, is in trouble before it comes off the press. New version will have five-digit codes, separate point values for different divisions, and new concept of "modifiers." Net result is a mathematician's dream and a physician's nightmare.

National Association of Blue Shield Plans and CHAMPUS have turned thumbs down on new CRVI. Concept of usual and customary fees is fast making relative value indices socio-economic anachronisms.

Big spender Robert Finch, HEW secretary, can't be all bad after recent decision on proposed new building for superagency. The secretary disapproved new $40 million monstrosity for HEW in Washington, saying costs were intolerable, design was offbeat, and space was wasted.

Ohio has become the seventh state to require fluoridation of public water supplies. Hard-fought campaign for enactment of law was joint M.D.-D.D.S. project with oral polio vaccine discoverer Albert Sabin as chairman. Ohio Dental Association put up $10 per member assessment to finance successful effort.

Legendary trust-buster Thurman W. Arnold of FDR era, died at Alexandria, Va., aged 78. He filed more than half of all antitrust suits in entire history of Sherman Act, successfully suing AMA in 1939 in celebrated Group Health Association case and later shattered Standard Oil Co.

Membership in MSMA will set new record high in 1969 with more than 1,440 physicians on rolls. Eight of 18 component societies show growth over 1968 with giant Central leading with 404 members. Five societies are static, three lost members, and two - Coast Counties and Singing River - actually represent gain after split this year.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

New 1040 Is Universal Return For 1969

Washington - You've got to see it to believe it, but the new 1040 federal income tax form is a 28-page, red, white, and blue booklet combining traditional return and instructions on how to send what you earned to Uncle Sam. Form series is progressive for complex tax situations, so taxpayer fills out only needed pages. New concept eliminates old short form. No need to worry about ordering one - everybody gets complimentary copy Jan. 1.

Michigan Blue Plan Is Target Of State Society

East Lansing - The Michigan State Medical Society recently acted on more than 20 resolutions zeroed in on Blue Shield. Toughest action was to initiate study on withdrawal of society approval. Other actions urged identification of Cross and Shield premiums payments, permission for medical society representatives to attend Blue plan board meetings, and distribution of plan by-laws to each member of Michigan house of delegates.

Judicial Council Rules On Family Treatment Charges

Chicago - The AMA Judicial Council has decreed that a physician may not "charge, or make a claim for, or receive compensation" for treating a member of his family. Ruling was made in response to inquiries about some physicians filing insurance claims under personal coverage after treating a member of their families. Ruling points out that it is violation of ethics to care for family members except for minor ills and emergencies.

Regional Medical Program Is Funded

Jackson - The Mississippi Regional Medical Program, based at UMC, received just over $1.5 million for current year for first operational activities. Projects include postgraduate institute; stroke unit, pulmonary, cardiovascular, neurological, and renal care programs; manpower; and radiation therapy training. Approval action brings operational RMP's to total of 44 in nation.

Chiropractors Try Again For Medicare Eligibility

Washington - Despite HEW report to Congress blasting chiropractic and recommending continued exclusion under Medicare, 57 House and two Senate bills have been introduced to pay the spinepunchers. The cultists have mounted a major campaign for federal recognition, swarming on Washington in a "piece (of the action) march."

It would utilize a system of Federal income tax credits to those individuals and families who purchase qualified health coverage from approved private insurance companies or plans.

In effect, Dr. Roth testified, a person's Federal tax liability would act as an index as to what share of the cost of his health insurance premium would be borne by the Federal government and how much would be paid by the individual.

For those individuals and families who, in terms of their tax liability, are in the bottom 30 per cent of taxpayers, health insurance protection would be provided without cost to them.

They would, Dr. Roth said, simply receive a certificate entitling them to free health insurance. They, in turn, would submit the certificate to a qualified company or plan. The private insurer who issues a comprehensive plan covering both hospital care and physicians' services would then be reimbursed directly by the Federal government.

Dr. Roth explained that as the individual or family's tax liability level rose, the Federal government would assume a smaller proportionate share of the cost of health insurance.

Federal tax credit would be subtracted from the amount of income tax owed the Federal government in a given year.

"For example," Dr. Roth said, "a taxpayer with a $500 tax liability might receive 70 per cent of the annual premium cost as a credit against his tax liability, and a family with a $1200 tax liability might receive 20 per cent of the premium expense. . . ."

He also proposed establishment of a "Health Insurance Advisory Board" to create Medicredit guidelines.

"This board, which would be chaired by the Secretary of Health, Education, and Welfare and include the Commissioner of Internal Revenue and public members," Dr. Roth stated, "would review the effectiveness of the program and file annual reports with the President and the Congress."

Basic medical benefits of Medicredit would include:

- Up to 60 days of inpatient hospital services, including maternity services;
- All emergency room and outpatient service provided in the hospital;
- All physicians services, whether performed in the hospital, home, office or elsewhere.

Supplemental benefits to basic coverage would also be eligible for tax credit.

In his testimony, Dr. Roth also stressed the importance of utilizing private insurance carriers, thus taking maximum advantage of private sector competition to help hold costs down.



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Contraindications: Because of the mild anticholinergic effect of orphenadrine, NORGESIC should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy, obstructions at the bladder neck, myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine. Do not use propoxyphene (Darvon®) concurrently.

Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child. USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when NORGESIC is administered to patients with renal disorders.

Adverse Reactions: Side effects of NORGESIC are those usually associated with APC or mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently, some degree of confusion in the elderly, mild central excitation and occasional hallucinations. These mild side effects are usually eliminated by reduction in dosage. One case of aplastic anemia, with no established causal relationship, has been reported.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

For more detailed prescribing information, see Package Circular or PDR.

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Alabama Names New Psycho-Social Chief

A Pittsburgh native has been named chief of the Psycho-Social Division, a unit of the UAB Medical Center's Regional Rehabilitation Research and Training Center, now in operation at Spain Rehabilitation Center. Dr. Karl Egerman's division of RRRTC will provide psychological and social service consultation to clients of the Center and their families.

"In addition to participation in the training of professional and sub-professional personnel," said Dr. Egerman, "the Psycho-Social Division will conduct research projects into the rehabilitation process. We would like to learn how individuals can utilize their existing abilities in overcoming problems of a psychological, social and economic nature; and how individuals can best learn to return to gainful employment and independent community living."

The RRRTC is one of a handful of similar centers across the country funded through the U. S. Department of Health Education and Welfare's Social and Rehabilitation Service.

Dr. Edward M. Holmes, Jr., UAB director of rehabilitation programs and project director for RRRTC, described the blanket program of which the Psycho-Social Division is a section as an effort to provide open research and training opportunities for faculty and students.

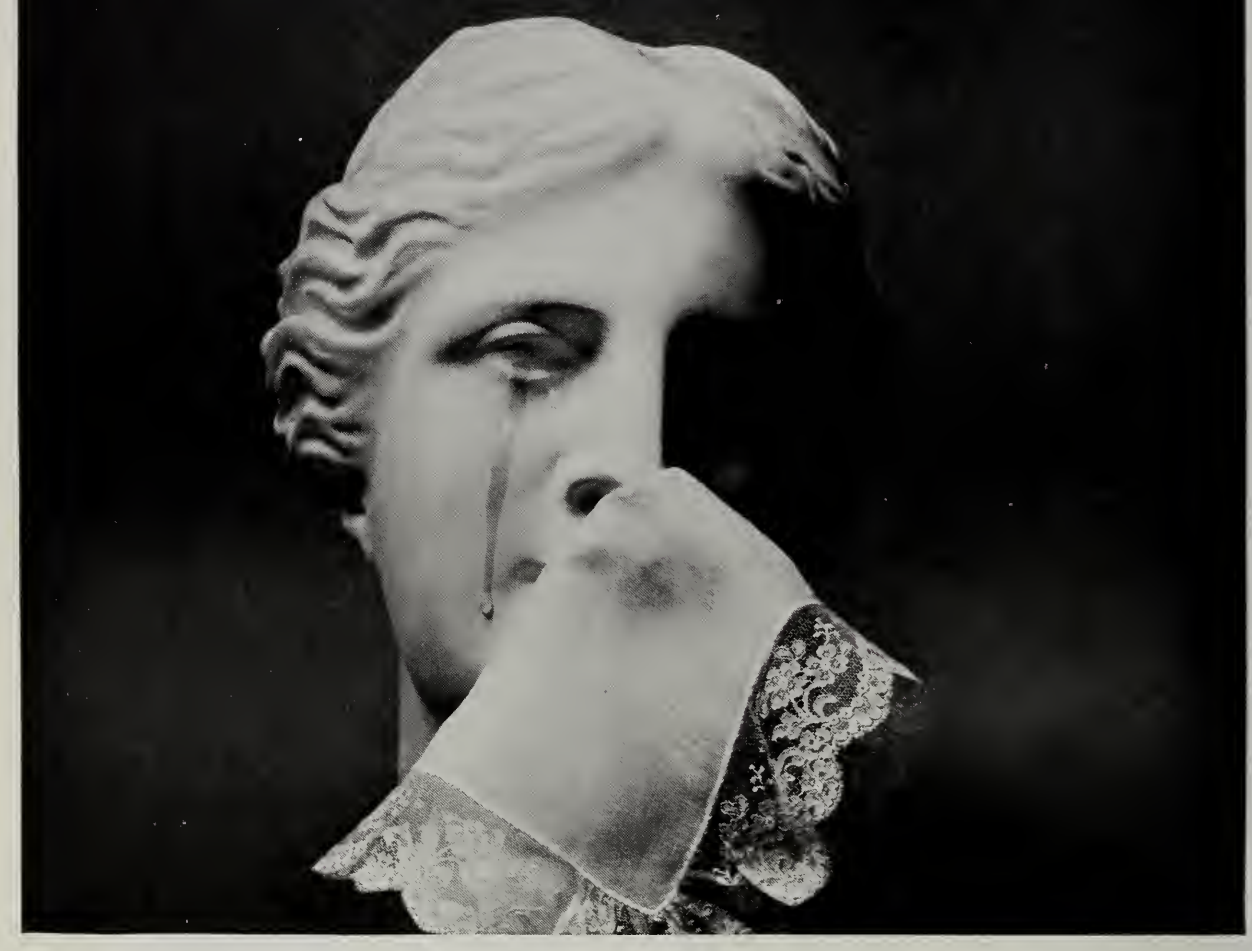
"We are primarily attempting to develop in the social aspects of rehabilitation, working closely with the socially-deprived and examining problems indigenous to families with handicapped members," he noted.

At UAB, Dr. Egerman will also hold an appointment as assistant professor of psychology, Department of Psychiatry, Medical College of Alabama.

For the three-year period prior to accepting his new appointment, Dr. Egerman served as director of research and, later, as director, Research and Training Center in Vocational Rehabilitation, Johnstown, Pa. He was employed in several research positions at the American Institute for Research, Pittsburgh (1959-65).

Past academic appointments were held at Carnegie Institute of Technology and the University of Pittsburgh. He lectured in an eight week seminar in urban problems, sponsored in 1965 by the National Conference of Christians and Jews.

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brand of sustained release capsules

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

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The first Medihaler was developed for the physician-inventor's own child.

The improved model you prescribe today is still made with the same painstaking devotion.

When your patient is in the grip of bronchospasm and reaches for his Medihaler, it must work. Not sometimes. Not most of the time. *Always.*

This is the ideal of perfection which has motivated the constant process of improvement of Riker's Medihaler.

Since its invention in 1956—when a Riker physician developed the Medihaler because of his determination to make better treatment available for his own asthmatic child—Riker has pioneered just about every significant forward step in bronchodilator aerosol therapy.

Riker developed the precision Medihaler valve, which assures the delivery of an automatically measured dose each and every time.

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SUMMARY OF PRESCRIBING INFORMATION

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Indications: Duo-Medihaler provides relief of dyspnea resulting from bronchospasm and congestion and edema of the tracheobronchial tree. It is indicated in:

1. Acute bronchial asthma and other allergic states
2. Chronic obstructive pulmonary diseases, such as chronic bronchitis and pulmonary emphysema.

Contraindications: Known hypersensitivity to either agent constitutes a contraindication to the use of this drug. Isoproterenol preparations are generally contraindicated in patients with pre-existing cardiac arrhythmias associated with tachycardia because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged, as it may lose its effectiveness. Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn.

Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Isoproterenol should not be administered with epinephrine, since both drugs are direct cardiac stimulants and their combined effects may produce serious arrhythmias. If desired, these drugs may be alternated, provided an interval of at least four hours has elapsed. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Duo-Medihaler should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

Adverse Reactions: Overdosage with isoproterenol can produce palpitation, tachycardia, tremulousness, flushing, anginal-type pain, nausea, dizziness, weakness and sweating, while overdosage with phenylephrine can induce cardiac irregularities, central nervous system disturbances and reflex bradycardia.

Dosage and Administration: The recommended dose for the relief of dyspnea in the acute episode is 1 to 2 inhalations. Start with one inhalation. If no relief is evident after 2 to 5 minutes, a second inhalation may be taken. For daily maintenance, use 1 to 2 inhalations 4 to 6 times daily or as directed by the physician. No more than two inhalations should be taken at any one time, nor more than 8 inhalations per hour, unless advised by the physician.

Caution: Federal law prohibits dispensing without prescription.

MEDIHALER-ISO® (isoproterenol sulfate)

Indications: Dyspnea, resulting from the bronchospasm associated with:

1. Acute bronchial asthma
2. Chronic bronchial asthma
3. Chronic bronchitis
4. Emphysema

And as an adjunct in the treatment of drug sensitivity reactions, injected allergens, urticaria, and other allergic manifestations.

Contraindications: Use of isoproterenol in patients with pre-existing cardiac arrhythmias associated with tachycardia is contraindicated because the cardiac stimulant effects of the drug may aggravate such disorders.

Warnings: See above. Do not exceed the dose prescribed by your physician. If difficulty in breathing persists, contact your physician immediately.

Precautions: Isoproterenol and epinephrine should not be used concurrently; combined effects may cause serious arrythmias. Their use may be alternated if an interval of at least four hours has elapsed. As with all sympathomimetic drugs, isoproterenol should be used with great caution in the presence of cardiovascular disorders, including coronary insufficiency, or when there is a sensitivity to sympathomimetic amines. Although there has been no evidence of teratogenic effects, use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to the mother and child.

Adverse Reactions: Only a small percentage of patients experience any side effects following oral inhalation of aerosolized isoproterenol. Overdosage may produce tachycardia with resultant coronary insufficiency, palpitations, vertigo, nausea, tremors, headache, insomnia, central excitation, and blood pressure changes. These reactions are similar to those produced by other sympathomimetic agents.

Dosage and Administration: See above.

Caution: Federal law prohibits dispensing without prescription.

Riker Laboratories, Northridge, Calif. 91324

$21,000,000 Construction Begins at UAB

A significant stride in the development of the Medical Center, University of Alabama in Birmingham, was achieved this month when contracts were awarded for construction of three major new buildings. More than $21,000,000 in state, federal and UAB funds will go into the projects—all expected to be completed within two years.

The buildings include the Basic Science Building, scheduled for completion in 1971; the Medical Center Library, to be completed within 12 months; and the Lyons-Harrison Research Building Addition Number Two, set for completion in 1970.

Funding for the Basic Science Building comes from the supplemental bond issue approved in the waning days of the 1969 Alabama legislative session; more than $8,000,000 of the $15,000,000 project will be provided by the National Institutes of Health, U. S. Department of Health, Education and Welfare.

The Medical Center Library, estimated to cost $1,300,000, will receive NIH and Alabama funding; the Lyons-Harrison addition, expected to cost $4,700,000, will be financed by UAB resources and NIH funds.

Announcement of the finalization of the construction plans was made by Dr. S. Richardson Hill, Jr., UAB vice president for health affairs.

"This huge package of construction is evidence of the Medical Center's great vitality—these buildings are urgently needed for established programs. Most importantly, the largest of the units, the Basic Science Building, will give us adequate space for greater numbers of medical and dental students."

The Medical College of Alabama increased enrollment from 85 to 100 freshmen students this year; plans call for another increase to 125 when the building is completed. At that time the School of Dentistry will go from 57 to 72 freshmen per year.

"Our educational programs at the Medical Center were given a great boost by the State Legislature in the recent session," Dr. Hill said.

Dr. Hill noted that the new library will provide the first central location for the Medical Center collection, and will allow for a substantial increase in scientific literature for the campus community.

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ORIGINAL PAPERS

The Zollinger-Ellison Syndrome: With Report of Illustrative Case

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Since 1955, over 350 cases of the Zollinger-Ellison syndrome have appeared in the literature. The authors discuss current methods of diagnosis concentrating on the symptoms and laboratory findings in the ulcerogenic syndrome. They present a case of a patient with the Zollinger-Ellison syndrome whose condition was diagnosed by bioassay.

In 1955, Zollinger and Ellison[1] first proposed as a clinical entity a syndrome of gastric hypersecretion and hyperacidity associated with non-beta cell lesions in the pancreas. They further postulated that the association was due to an ulcerogenic humoral factor elaborated by the pancreatic lesion. In 1960, Gregory[2] first extracted a gastrin-like substance from a non-beta cell tumor in a patient with the Z-E syndrome. Since 1955, over 350 cases of the Zollinger-Ellison syndrome have appeared in the world's literature.[3] The purpose of this paper is to present an interesting case of a patient with the Z-E syndrome along with a discussion emphasizing current methods of diagnosis.

E. B., History No. 195780, a 19-year-old Negro male was first admitted to the University Hospital for intractable epigastric pain of eight months duration which frequently awakened him in the early morning hours and which was partially relieved by food. The pain was associated with intermittent nausea and vomiting. Four months prior to admission, he had been treated symptomatically by his local physician without improvement. Two months prior to admission he had developed watery diarrhea, and two weeks later he had experienced several episodes of hematemesis and melena. At that time he was admitted to his community hospital where an upper gastrointestinal series was interpreted as showing an active duodenal ulcer. Despite vigorous symptomatic therapy, the pain, nausea, vomiting and melena persisted, and he was referred to the University Hospital. He had lost 50 pounds during the eight months of illness. There was no family history of ulcer disease, endocrine disease or cancer.

On physical examination his nutrition, development and vital signs were within normal limits, as were the heart and lungs. There was no hepatosplenomegaly, masses or tenderness, but rectal examination revealed Hematest positive stools. The abdomen had a normal contour.

The initial hemoglobin and hematocrit levels

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were 12.8 gm/100 cc and 36 per cent, respectively, after the transfusions given at the previous hospital. The white cell count was 13,600 with 61 per cent segs, and the urinalysis was within normal limits. The blood urea nitrogen level was 24 mg. per cent and the serum electrolytes were normal. The liver battery revealed the following: total bilirubin 0.3 mg. per cent with 0.1 mg. per cent direct, alkaline phosphatase 18KA units, SGOT 44 units, total serum proteins 6.8 gm. per cent with albumin 3.5 gm. per cent, uric acid 10.3 mg. per cent and first stage prothrombin time 40 per cent. There was a 4 per cent bromsulfalein retention at 45 minutes. Repeated two-hour post-prandial serum glucose levels were around 220 mg. per cent, suggesting mild diabetes mellitus.

The serial serum calcium levels were 5.8, 5.9, and 5.9 mEq/L and serum phosphorus levels were 4.3, 4.1, and 5.0 mg. per cent. Serial amylase values were 492, 462, and 388 S. U. Urine 17-ketosteroid excretion was 17.9 mg/24 hours. Chest and skull films were normal, but an upper gastrointestinal series was interpreted as showing a large duodenal ulcer with marked mucosal reaction in the duodenum. No other abnormalities were seen in the small bowel. A liver scan revealed multiple areas of decreased uptake compatible with metastatic disease.

ACID OUTPUT

The basal acid (stomach) output (BAO) was 190 ml/hr with 29 mEq/hr of free acid, and the maximum acid output (MAO) (*i.e.,* posthistalog stimulation) was 395 ml/hr with 70 mEq/hr free acid. The BAO/MAO x 100 per cent was 41 per cent. Gastric cytology was Class O. A bioassay for circulating gastrin using the patient's serum was repeatedly positive (*i.e.,* repeated infusions of the patient's serum into rats caused a 100 per cent increase in acid production over the rat's own basal acid output). The clinical impression at this time was that the patient had severe intractable duodenal ulcer disease, probably associated with a Zollinger-Ellison tumor (an ulcerogenic non-beta cell lesion of the pancreas). The elevated amylase suggested that there might be a posterior perforation of the duodenum into the pancreas.

The patient was treated with a bland diet, antacids and anti-cholinergics, and his pain and nausea diminished initially. However, on April 30, 1968 he underwent an exploratory laporotomy where 5 x 6 cm. and 3 x 2 cm. masses were found in the head and tail of the pancreas respectively, and "metastatic" nodules were generalized throughout the liver. After a liver biopsy which revealed probable Z-E tumor metastases, a total gastrectomy with esophago-jejunostomy and entero-enterostomy was performed. Final pathology sections of the liver biopsy were interpreted as reflecting a metastatic but well-differentiated tumor with characteristics of an islet cell adenocarcinoma, though carcinoid tumor could not be completely excluded. The postoperative course was uneventful, and he was discharged doing well on six small feedings per day but no medication.

POSTOPERATIVE COURSE

The patient continued to do well until July 1968, 10 weeks postoperatively, when he presented to the clinic with epigastric pain, nausea and hepatomegaly. An upper gastrointestinal series was within normal postoperative limits. demonstrating patent anastomoses and no evidence of marginal ulceration. By August 1968. he had developed intermittent watery diarrhea and increased hepatomegaly. A liver scan revealed a progression of disease, but a long bone survey was normal. In late October, he presented with increasing abdominal pain, 4+ pitting edema of the lower extremities and an enormously enlarged liver that was palpable at the left iliac crest.

Liver battery at this time revealed alkaline phosphatase 351 units, SGOT 100 units, total bilirubin 0.3 mg. per cent, total serum proteins 7.6 gm. per cent with 3.7 gm. per cent albumin and prothrombin time 25 per cent. Repeated urine 5-hydroxyindoleacetic acid determinations were negative. He was treated with diuretics and serotonin antagonists. The edema and pain responded somewhat, but by Nov. 5, 1968, he developed severe epistaxis, edema of the upper extremities, and neck vein distension. The epistaxis was controlled, he was treated with diuretics and digitalis, and he lost 11 pounds of edema fluid in two days. However, on Nov. 15, 1968, he died quietly at home and autopsy was not performed.

DISCUSSION

Preoperative diagnosis of patients with the Z-E syndrome may be difficult at best. Even at surgery definitive diagnosis may be impossible. According to Ellison and Wilson's[4] evaluation of

260 collected cases, only 32 per cent of the cases were diagnosed at the first operation and 33 per cent were diagnosed at autopsy. Most deaths could be attributed to complications arising from great acid output. In fact, up until 1967 only nine documented cases had died from tumor proliferations per se.[3] Their study revealed the following survival rates with various types of therapy: with no gastric resection 22 per cent had survived, with a subtotal gastrectomy 47 per cent had survived, with a subtotal gastrectomy followed by total gastrectomy 70 per cent had survived, and with initial total gastrectomy 100 per cent had survived. When tumor excision was feasible, there was a 52 per cent survival with subtotal gastrectomy and 86 per cent survived with total gastrectomy. With tumor excision alone only 18 per cent survived. Thus, even with apparent total tumor excision, total gastrectomy is the treatment of choice. Further, it may be seen that if the diagnosis is made prior to the first operation, or if there is a high index of suspicion, the early mortality rate of patients with the Z-E syndrome can be lowered from 30 to 50 per cent by performing a total gastrectomy initially. Therefore, early diagnosis is very important.

CLINICAL FEATURES

The incidence of the Z-E syndrome in the general population, once thought rare, is being diagnosed with increasing frequency. This is undoubtedly due to an increased awareness of the syndrome by the physician and to better diagnostic aids. The male to female ratio is 3:2 with no apparent selection of races or geographical areas. The age of onset usually occurs in the third or fourth decades, although cases have been reported from 9 to 90 years. Forty-six per cent of the tumors have been found to be malignant, but this figure may increase as the number of deaths due to gastric hyperactivity is reduced, thus permitting patients to live longer and give the tumors more time to exhibit malignant changes. According to Ellison's and Wilson's study,[4] there was no significant family history of peptic ulcer disease or the multiple endocrine adenosis syndrome (Werner's disease) in patients with Z-E tumors. However, recent studies suggest that there may indeed be a genetic factor in the Z-E syndrome, leaving the exact relationship between Werner's disease and the Z-E syndrome unsettled.

Almost all the symptoms of the Z-E syndrome can be attributed to the very large volume of gastric secretion containing huge amounts of hydrochloric acid. Most patients present with an 8-12 month history of burning mid-epigastric pain of peptic ulcer disease, which has not responded to either vigorous medical or surgical treatment. A small number present with generalized cramping abdominal pain which is often associated with diarrhea and is thought to be due to hyperperistalsis. Also included in this group are those patients who have developed some degree of pyloric or small bowel obstruction. Another small group may present with the sharp, continuous pain of viscus perforation and may or may not have had previous symptoms of peptic ulcer disease. The perforation usually involves the proximal duodenum, but may involve the stomach, distal duodenum or jejunum. Over one-half of these patients will have had previous surgery with some type of gastric operation performed. As in usual peptic ulcer disease, if the perforation involves the posterior wall of the duodenum, the patient may present with symptoms of bleeding or acute pancreatitis.

The second most common presenting complaint is diarrhea, which is usually associated with vomiting. Originally, the diarrhea was believed to be caused by both the large volume of fluid continuously passing through the gut and also to bowel wall irritation by large amounts of acid, since there is a cessation of the diarrhea with continuous naso-gastric suction in many cases. Now some authors believe that some Z-E tumors elaborate a hormone capable of stimulating secretion of succus entericus[3] and Zollinger et al[5] have suggested that this substance is secretin. Certainly, diarrhea may exist without hyperacidity. The stools are usually watery, brown, and unoffensive with small amounts of mucus. Steatorrhea has been reported in a few cases. The number of stools per day need not be large, with most patients having 5-7 bowel movements per day.[3]

ASSOCIATED LESIONS

About one patient in five will present with either melena, hematemesis or both. The amount of bleeding may vary from small amounts to massive hemorrhage and may originate anywhere in the esophagus, stomach or small bowel.

About 21 per cent of the patients with the Z-E syndrome have been found to have an associated endocrine lesion. About one-half of these had one other gland involved, and the other half two or more endocrine lesions. The glands in order of frequency of involvement have been

parathyroid, adrenal, pituitary, pancreas (insulinomas) and thyroid. About one-third of the patients with a parathyroid lesion had clinical hyperparathyroidism, and about one in eight with an adrenal lesion exhibited clinical evidence of hyperadrenocorticism (Cushing's syndrome). Adrenal medullary lesions have apparently been rare.

While it might appear reasonable to expect that untreated patients with the Z-E syndrome would have a rapid and fulminating course, Ellison and Wilson[3] reported that 80 per cent of reported cases had had symptoms greater than one year and that 25 per cent had had symptoms greater than five years. Thus, as more and more cases are reported, the course of the disease is being found to vary from relatively long duration with mild symptoms, which is easily mistaken for ordinary peptic ulcer disease, to a "galloping" disease.

ASSOCIATED DIARRHEA

Again, although peptic ulcer symptomatology alone constitutes the presenting complaint in the majority of patients, about 30 per cent have associated diarrhea. About 40 per cent of these develop symptoms of peptic ulcer disease followed by diarrhea, while 60 per cent have a history of diarrhea that antedates the symptoms of peptic ulcer disease. Furthermore, about 7 per cent of all patients with Z-E tumors have been found to have diarrhea without symptoms of peptic ulcer disease,[4] and most of them have exhibited severe hypokalemia. The relationship between ulcer symptoms and endocrine symptoms is not well defined, but it should be pointed out that several cases have been reported where the symptoms of an endocrine disorder antedated any gastrointestinal symptoms.

Gastrointestinal hemorrhage and prolonged vomiting may produce an iron deficiency anemia or marked electrolyte imbalance, and thus routine studies may be helpful. Also, since 21 per cent of the patients with Z-E tumors have an associated endocrine lesion, tests for other endocrine disorders should be obtained, including serum and urine calcium and phosphorus, 24-hour 17-hydroxycorticosteroids and 17-ketosteroids, a glucose tolerance test and PBI and T-3 levels.

More specifically, a very useful adjunct in diagnosis is the gastric analysis. Most (75-85 per cent) patients will have a twelve-hour overnight gastric secretion of 1000 cc. or more (normal < 200 cc.) with the free acid content of 100 milliequivalents or more (normal < 20 mEq). The basal acid output (BAO) ranges from 20-40 mEq/hr (normal < 2 mEq/hr). When the augmented histamine stimulation test is performed for maximum acid output (MAO), over three-fourths will demonstrate less than a 25 per cent increase in the BAO (normal increase, 40-60 per cent). This may be explained when one realizes that even at rest the parietal cells are at near maximum stimulation due to the circulating gastrin-like hormone.[4]

DISEASE VARIATIONS

When the values for the gastric analysis fall in these ranges for a Z-E tumor, the pathological diagnosis is presumed. However, there are documented cases of the Z-E syndrome where the volume and acid output were normal, and in some rare cases achlorhydria has been reported. Also, some patients with ordinary peptic ulcer disease may secrete large volumes of fluid and acid that may overlap the lower limits for values seen in the Z-E syndrome. Furthermore, when patients with known Z-E tumors undergo repeated gastric analysis, it has been shown that the results sometimes implicated an ulcerogenic tumor syndrome and sometimes not. These variations illustrate the need for repeated gastric analyses before completely ruling out the Z-E syndrome.

BIOASSAY METHODS

The diagnostic uncertainty that inherently exists in the gastrics analysis prompted the search for a reliable laboratory method. Sircus[6] first suggested using bioassay methods for diagnosing the Zollinger-Ellison syndrome preoperatively. Later Bonfils et al[7] did similar studies. In 1967, Moore et al,[8] using a method first devised by Lai,[9] reported four cases in which the diagnosis of the Z-E syndrome had been made preoperatively by a rat bioassay method. Since then much interest has been expressed in bioassay methods with several groups reporting varying degrees of success. Basically, the method consists of the infusion of either patient urine or serum into the femoral vein of a rat and monitoring the change in output of acid from the gastric mucosa by collection through a total gastric fistula. The rats are first infused with normal saline to determine the basal acid output and then with purified gastrin to eliminate all rats which will not respond appropriately.

A wide range of results have been obtained.

In most laboratories an assay is considered positive when there is a 100 per cent increase in the BAO following infusion of the patient's serum in a test rat. When these rigid standards for a positive test are imposed, there are infrequent false positives (< 1 per cent), but there are relatively frequent false negatives—though the incidence of both false positives and negatives has varied in different laboratories. There are probably two reasons for false negatives: (1) the assay method may not be sensitive enough, and (2) there may be a wide range of serum gastrin levels in Z-E patients.

Due to dose-response relationships and varying degrees of gastrointestinal resistance to acid-pepsin irritation, some patients may exhibit symptoms of severe ulcer diathesis with only modest serum gastrin levels, too small to be detected by present bioassay methods (but perhaps detectable in the future by the immunoassay method). Other patients may require very high levels of gastrin to produce acid-pepsin ulcers or diarrhea. Furthermore, the relationship may be time related, i.e., a certain length of time may be necessary for gastrin to reach a measurable level.[10] We had one patient diagnosed by bioassay in which previous bioassays for gastrin had been repeatedly negative: over the course of a year the assay became positive and a Z-E tumor was found at laparotomy.[10]

NEGATIVE ASSAYS

Like histamine, very large amounts of gastrin may actually cause inhibition of acid secretion, so that test animals may give negative bioassays in patients with high levels of circulating gastrin. Finally, some patients with the Z-E syndrome may have negative assays because the level of gastrin is not elevated. This is supported by the finding that experimenters have not been able to extract gastrin from all Z-E tumors. Thus, in view of these several considerations, a useful rule to apply to gastrin bioassay in diagnosing the Z-E syndrome is as follows: a patient with a positive bioassay must be treated as having the Z-E syndrome until proven otherwise, but in a patient with a negative bioassay the syndrome cannot be ruled out on this test alone.

The ultimate in diagnostic methods would be the quantitative measurement of gastrin or its breakdown products in the serum or urine. McGuigan[11] first performed immunochemical studies using synthetic human gastrin. Recently Stremple[12] has developed a radioimmunoassay technique for gastrin determination which is very sensitive. His initial studies confirm immunologically that there is a wide range of gastrin levels secreted by Z-E tumors. Vatier and co-workers of Bonfils group[7] have with chromatography identified a urinary secretory factor believed to be a breakdown product of gastrin, but their studies are in the initial phases.

ROENTGEN DIAGNOSIS

According to Wilson and Ellison's study,[4] 93 per cent of patients with Z-E tumors will develop roentgen evidence of a peptic ulcer. While the syndrome originally attracted attention because of multiple ulcers or ulcers with atypical locations, 90 per cent of the cases had single ulcers and only 25 per cent were found in atypical locations. The overwhelming majority of them were found in the first part of the duodenum. However, when multiple ulcers are demonstrated or when an atypically situated ulcer is shown, it is almost pathognomonic of the Z-E syndrome. Other radiological findings may be variable and extreme. Frequently, significant amounts of fluid can be seen in the stomach after an overnight fast. The stomach may be "large and boggy" with a decrease in the amplitude and frequency of peristalsis. Occasionally, there are large gastric folds simulating Menetrier's disease. The duodenum may be greatly dilated distally, with greatly decreased inability.[13] The small bowel may show segmentation and flocculation of barium, mimicking a "lace like or cob web" pattern, with loss of its architectural pattern. Also, there may be evidence of marked hyperactivity with a decrease in emptying time. Any or all of these findings may be apparent, but some patients may have perfectly normal upper GI and small bowel series.[4]

SCANNING

In recent years, more and more work has been done in the field of pancreatic scanning. Using ^{75}Se selenomethionine, visualization of the pancreas is becoming fairly routine. Even though there are many variations of the normal scan, certain patterns of abnormality have become apparent: spotty uptake with neoplasms (filling defects) and diffuse reduction of uptake with pancreatitis. To date, there has been only one documented case of a Z-E tumor being outlined by pancreatic scanning, and in that case there was an increased concentration of selenomethionine.[14]

Perhaps this fact, coupled with the fact that Z-E tumors are often multiple, may serve as a useful method of diagnosis. Moreover, with the recent advent of selective celiac arteriography, it may be possible to locate a Z-E tumor by finding "tumor patterns" in the arteriogram. Finally, since the liver is a frequent site of metastasis, liver scanning and arteriography may locate evidence of metastasis even when the primary tumor cannot be located.

DEFINITIVE DIAGNOSIS

As mentioned earlier, diagnosis may not be easy even at surgery. This is due in part to the fact that generally Z-E tumors are small (usually less than 2 cm. in diameter), and that they may have rather atypical locations, including the duodenal or paraduodenal walls. Also, the disease may be due to islet cell hyperplasia without true tumor demarcation. Most of the malignant tumors are multiple, and single tumors are found four times more frequently in the head and tail than in the body of the organ. In those cases diagnosed in Ellison and Wilson's study, 72 per cent had an obvious lesion in the pancreas at the time of surgery. Of these diagnosis was confirmed by biopsy and/or excision of the pancreatic lesion (48 per cent), partial pancreatectomy for visible or palpable lesions (36 per cent), and biopsy of an invasive tumor mass or metastasis (usually in the liver) (16 per cent). Of the 28 per cent in which there was no apparent pancreatic lesion, the diagnosis was made by lymph node biopsy (30 per cent), blind hemi-pancreatectomy (30 per cent), biopsy of a duodenal or paraduodenal wall (20 per cent), and postoperatively from resected stomach, duodenal wall or lymph node (20 per cent).[4]

THOROUGH SEARCH

With this many methods needed to obtain a definitive diagnosis in some cases, it is apparent that a thorough search must be made if the tumor is to be found consistently. This means that the entire pancreas must be examined from the head to the tail, both anteriorly and posteriorly, using the Kocher maneuver. The duodenum and stomach walls should be examined carefully, preferably with one finger within the lumen. Multiple lymph node biopsies with frozen sections may be of benefit, with the paraduodenal and peripancreatic nodes being involved most often. Finally, if all this fails and if laboratory and radiologic tests justify it, blind hemipancreatectomy should be performed.[3]

SUMMARY AND CONCLUSIONS

The case of a patient with the Zollinger-Ellison syndrome diagnosed by bioassay has been presented. The symptoms, laboratory findings and diagnostic problems met in the ulcerogenic syndrome have been discussed. The Z-E syndrome should be suspected whenever a patient presents with unusually severe or intractable peptic ulcer disease, multiple or atypically located ulcers, a rapid fulminating course, peptic ulcer disease with chronic diarrhea, and peptic ulcer with signs or symptoms of another endocrinopathy.

The most useful laboratory screening test is the gastric analysis with an augmented histamine stimulation test. Bioassay is becoming more useful and radioimmunoassay and chromatography methods are very promising. Roentgenographic studies usually demonstrate typical duodenal ulcers, but may reveal multiple or atypically located ulcers. Scanning and arteriography of the liver and pancreas may play increasingly important roles in diagnosis. At operation a thorough search may be necessary to locate the tumor. Definitive therapy is surgical resection of the tumor, if possible, along with total gastrectomy. Finally, if a definitive diagnosis can be obtained, and if definitive therapy is used, the longevity of patients with the Z-E syndrome can be substantially prolonged. ★★★

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FIFTH AND FAITHFUL

He was the town ne'er-do-well. I'd delivered his wife of four daughters in as many years without once being paid. When he got me out of bed at 2 o'clock one winter night as the mercury hovered near zero, I was all set to give him a piece of my mind. But he spiked my guns by saying, "My wife's having another baby, Doctor. The pains are coming about five minutes apart. She told me to go to another doctor so's not to bother you again; but I didn't want to hurt your feelings. After all, *you're* our family doctor!"

—*John Evans, M.D.*

Experiences With Electrical Cardioversion In an Outpatient Clinic

JOHN H. WOODBRIDGE, M.D.
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MOST CARDIAC ARRHYTHMIAS produce symptoms. These symptoms may be palpitation or pain or dyspnea or cough or a combination of these. Excluding infrequent premature contractions, most cardiac arrhythmias are abnormal and interfere with cardiac or pulmonary function and most occur in the presence of heart disease.

One of the most frequent abnormal arrhythmias is atrial fibrillation. Other common arrhythmias fall in the tachycardia group, paroxysmal, supraventricular and ventricular. Since these arrhythmias cause symptoms and interfere with function, treatment is usually indicated. Hospital beds are at such a premium that it seemed worthwhile to investigate methods of treating arrhythmias promptly and effectively in an outpatient clinic and determine whether or not a more serious or acute underlying disturbance precipitated the arrhythmia.

Before 1962, arrhythmias were treated medically by titrating various drugs in patients to interrupt or over-ride the arrhythmia. This was a time-consuming technique. Sometimes, although infrequently, certain physical stimuli could interrupt certain arrhythmias; but this was unusual. Beginning in 1963, many reports have been made in medical literature of an electrical method of treating several types of arrhythmias.

Over the past seven years one particular method has become almost universal. This is the Lown technique of electrical cardioversion. Time has proved its value, its simplicity, its reliability, its safety and its paucity of complications. The principle of selective electrical cardioversion is the use of a 16 microfarad capacitor as the source of electrical energy in series with an inductor delivering an underdamped discharge of (2.5) milli-seconds duration through a time-delayed circuit triggered by the R wave of the ECG. Put another way, it is the use of an (almost) instantaneous capacitor discharge of direct current during a pre-selected safe period in the cardiac cycle. Electrical stimulation of the heart produces ion movements in the myocardium which affect electrolyte gradients at the cellular level.

Applying the principles of the Lown technique of electrical cardioversion, 232 outpatients with cardiac arrthythmias received 526 DC countershocks in the series reported in this paper. The success rate was 96 per cent. The Lown technique and the modifications used in this series are discussed in detail.

The instrumentation market is flooded nowadays with many manufacturers' machines, all utilizing in general this same principle. Success in treating various cardiac arrhythmias with DC countershock exceeds 75 per cent; success in converting atrial fibrillation exceeds 95 per cent. Conversion relieves the symptoms and improves cardiac function. Exercise becomes more tolerable. In atrial fibrillation, conversion increases cardiac output. Stroke output is more constantly maintained. Therefore it seems prudent and important to use this simple and effective and im-

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Read before the 101st Annual Session, Mississippi State Medical Association, Biloxi, May 12-15, 1969.

mediate method in the treatment of many arrhythmias.

Cautiously developing a procedure to fit the needs of patients who frequently revert to atrial fibrillation or develop attacks of other arrhythmias, a technique has been used in 232 patients 526 times to regain sinus rhythm as soon as the patient noted pain or palpitation of fluttering or when an irregular pulse developed. This required making electrical cardioversion available day and night, every day, and having a physician available who could obtain quickly the record of the patient of previous cardioversions and who could be relied on to follow certain principles unerringly and reliably. This required a ready file, concise patient data, and ease and assurance to the patient.

The emergency room of any hospital, outfitted with a cardio-pulmonary resuscitation unit, is an adequate environment. Anti-coagulation is not used nor is it discontinued if the patient is taking anti-coagulants for some other reason. It has not been shown to be necessary in such an outpatient traffic.

LOWN'S TECHNIQUE

Lown's technique has been modified in very minor ways. As soon as a patient arrives, a standard ECG is made to determine the cardiac rhythm and any underlying acute embarrassment which may have precipitated the arrhythmia. If the arrhythmia is of a type which responds to electrical cardioversion such as atrial fibrillation, ventricular tachycardia, supraventricular tachycardia, and if the patient has not eaten for two hours, if there is no history of embolic or thrombotic episodes (since the last cardioversion), the patient is placed in a supine position on an examining table without a pillow. Five to ten mgs. of diazepam, depending on the patient's status and size, are given slowly intravenously. Within 3 minutes the patient usually has slurred speech and the appropriate direct current countershock is administered using anterio-posterior paddles. One paddle is placed under the patient just below the left interscapular area, rarely in the axillary area, using the patient's own weight to stabilize it; the other paddle is centered firmly but gently over the second right intercostal space at the sternal border. Generous amounts of electrode jelly cover the paddles. When it is determined that there is safety and no bleed-off of current, the shock is administered. The shock usually causes the patient to flex the arms and knees moderately and to groan momentarily.

Within 15 seconds to 3 minutes, a normal sinus rhythm is usually noted on the oscilloscope and the continuously running electrocardiogram. Monitoring is continued for 30 minutes in the average patient. Within 5 minutes of the beginning, the patient is awake but drowsy. Within 30 minutes the patient is ambulatory and remembers the shock without pain or fear or horror. Usually, the next day the patient only remembers the total episode with a short hiatus of time (no actual remembrance of the shock itself). Most patients leave for home in one hour, the whole episode requiring less than 1½ hours. Sometimes a second or third shock is given before sinus rhythm is restored. If over 3 shocks are required, a time lag is planned to review medications and activity. If the pre-shock ECG shows digitalis-like toxic signs, plans including the use of potassium, propranolol, and glucagon evolve to synergize with the DC countershock.

Our experience includes 232 patients. Two-thirds of the arrythmias occurred after the sixth decade. Males slightly outnumbered females. These patients had received DC cardioversion at least once previously while hospitalized, except for 11 cases of P.A.T. which seemed so classical that out-patient cardioversion was employed without hospitalization. The arrhythmias were divided into diagnostic categories, with cases of recurrent bouts of atrial fibrillation predominating. The Watt-second current (Jules) used was usually between 150-250. Results were considered to be successful if a normal sinus rhythm was produced within 3 minutes and persisted for 24 hours. Sometimes, as many as 3 shocks were given to obtain reversion. All patients were continued on maintenance therapy of some anti-arrhythmic drug. Some of the cases of P.A.T. were managed with phenobarbital.

PREVENTIVE MEASURES

Electrical cardioversion does not remove the necessity for using antiarrhythmic agents. The preventive use of quinidine, procainamide, barbiturates and Dilantin, to prevent reversion to the arrhythmias must be continued. Digitalis glycosides or leaf and other cardiovascular medications are continued without interruption, although dosages may be altered.

Since using diazepam, no respiratory difficulty and no distressing memory of the event have occurred. One patient died suddenly at home 36 hours after a single DC countershock, although he had undergone electrical cardioversion with identical technique on four previous occasions.

Autopsy was refused. His severe chest pain just preceding death may have been due to myocardial infarction or a dissecting aneurysm. He had massive cardiomegaly, arteriosclerotic heart disease and left ventricular enlargement.

COMPLICATIONS

Electrical cardioversion is a simple clinical modality, but there are certain complications that have been reported and that do occur. The most frequent is an arrhythmia. This is usually transient. Rarely, ventricular fibrillation, cardiac arrest and diminished cardiac output occur. The cardioversion-defibrillation machine stands ready to repeat the use of direct current countershock when indicated for one of these complications. A suction machine is available in case of vomiting or retching. Various kinds of airways are kept at hand including endotracheal tubes. A positive pressure breathing machine stands by in case of need, along with oxygen. Various cardiac drugs are available. These are precautions which are useful in case of need although none has ever had to be used in this outpatient clinic. Embolization has not occurred in this series and is reported to be less than 2 per cent (Bellet) in various series. It is an over-emphasized hazard and should not prevent the use of countershock. In the outpatient population where recurrences of arrhythmias are treated immediately, we do not use anticoagulants specifically. If a patient develops an embolic episode, we are prepared to begin treatment immediately.

SUMMARY

In summary, applying the principles and some modifications of the Lown technique of electrical cardioversion, 232 outpatients received 526 DC countershocks to give a success rate of 96 per cent. It is a safe, simple and reliable clinical modality to be used to relieve symptoms and improve cardiac function in various recurring cardiac arrhythmias. ★★★

4527 Maryland Avenue 63109

DOUBTFUL COMPLIMENT

At a faculty dinner party a shy young teacher had been trying to think of something nice to say to his hostess. His chance came when she turned to him and remarked, "What a small appetite you have tonight, Mr. Green."

"To sit next to you," he said gallantly, "would cause any man to lose his appetite."

Clinicopathological Conference XCV

Conducted by the Department of Pathology
Mississippi Baptist Hospital
Jackson, Mississippi

THIS 66-YEAR-OLD, white, male, oil field worker entered the hospital because of inability to walk and also because of severe hypertension. During the week before admission the patient had noted instability and falling when trying to walk, and for the past three days he had not been able to walk at all or to stand up, with a tendency to fall to the right. He was able to move his legs, however. He had vomited, and increasing somnolence and dullness had been noted. For several years he had suffered severe, frontal to bitemporal headaches, and these had been more persistent and severe for the previous two to three months. Skull films, taken on the outside a month prior to admission, had been negative. There was no history of chills, fever, seizures, or head injury.

The patient had been a known hypertensive for many years, with blood pressures around 220/110, and investigation in the past had shown a poorly functioning right kidney, attributed to chronic pyelonephritis. He also had chronic pulmonary disease and emphysema, for which he had been using Isuprel inhalations; he had been using Isuprel excessively recently.

On examination the blood pressure was 230/160 in the right arm, and 220/140 in the left arm. A grade II systolic murmur was heard at the apex, and the prostate was 4+ enlarged, firm and hard. The rest of the general physical examination was unremarkable. On neurological examination, the patient was described as semistuporous, with very limited responses, listless, with little affect, but oriented in all spheres. He was weak and generally hypotonic. No lateralizing signs or reflex changes were noted. There appeared to be some pain in the retro-orbital and frontal areas with movement, but no nuchal rigidity. He was thought to have loss of gaze to the left, with the left eye questionably rotated outward. The visual fields were thought to be probably full. The optic discs were not well visualized.

The patient in this month's CPC is a 66-year-old oil field worker who entered the hospital because of inability to walk and severe hypertension. During the week before admission he had vomited, and increasing somnolence and dullness had been noted. Discussers are Drs. William E. Bowlus, Ottis G. Ball, and William B. Wilson.

The hemoglobin was 16.8 gm. per cent, hematocrit 51 per cent, white count 13,700 with 87 per cent segs and sed rate and VDRL normal. The BUN was 89 mg. per cent, the CO_2 combining power 35.5 mEq./L., the chloride 103, potassium 4.6, and sodium 146 mEq./L. Spinal fluid pressure was "elevated," with water-clear fluid, showing 74 mg. per cent protein. 2 lymphocytes, and negative serology.

A skull film was normal. A brain scan was "not very satisfactory, the PA projection showing a little rotation, and the AP projection not being obtained." On the PA projection there was thought to be possibly a little heaviness on the right side toward the periphery of the skull, and the lateral film showed no difference on either side. No definite abnormality was thought to be

present. An arteriogram showed no evidence of subdural hematoma, aneurysm, vascular displacement or tumor stain. There was slight question of relative avascularity high on the right side, when compared with the left, but this was not well shown on the lateral projection, and no definite abnormalities were thought to be revealed by the arteriogram. A chest film was unrevealing. An EKG showed left ventricular hypertrophy.

THERAPEUTIC MEASURES

The patient was started on Rauwiloid, 2 mg. t.i.d., and, in addition, received Serpasil, 1.25 mg. IM. His blood pressure remained elevated, at around admission levels, however. On the day after admission the temperature rose to 101.8° (R). On the third day, the temperature ranged from 100-101° (R), the hypertension persisted and he was unimproved, and the pulse rate gradually rose to around 120 to 150 and was described as "weak." The respiratory rate rose to 28 per minute, and the mucous and bronchial secretions became a problem. Antibiotics were started. He was digitalized, although overt failure was not thought to be present, and another injection of 1.25 mg. of Serpasil was given IM. He was thought to move his right limbs more than the left, but his state of consciousness was unchanged. He had no seizures and was not thought to have CO_2 narcosis. Urinary output remained good. The pulse rate returned to 90-120 after digitalization was accomplished and Isuprel was discontinued. On the fourth day the temperature again became elevated, ranging from 100.4° to 102.6° (R). On the afternoon of the fourth day the blood pressure began to drop gradually from 210/116 to 100/60, over a nine-hour period. The pulse during this time was variously recorded from 88 to 138 per minute and was irregular. The patient was described as "cold." Aramine was given and the blood pressure stabilized for a few hours, but then continued to drop. The patient became confused and disoriented, and expired on the fifth day.

Dr. William E. Bowlus: "The CPC tonight is the case of a 66-year-old, white, male, oil field worker who was admitted with the chief complaint of inability to walk and severe hypertension. The history of his present illness was that for one week prior to admission he had complained of instability in walking, and occasionally falling, and for three days prior to admission he was unable to walk or stand and would tend to fall to the right if they did stand him up. He was still able to move his legs. He began to vomit, and then developed increasing somnolence. There was no history of any head injury, and he denied other neurologic symptoms. According to the past history, he had had severe frontal and bitemporal headaches for years, but these had seemed to be worse for the past two to three months. He was hypertensive, with his blood pressure running in the range of 220/110 for years, with a poorly functioning right kidney thought to be due to pyelonephritis. He also had had emphysema for many years, and he used Isuprel excessively.

"On physical examination, his blood pressure was 230/160 in the right arm and 220/140 in the left arm. He had a grade 2, apical systolic murmur, and the prostate was 4+ enlarged and hard. On neurologic examination he was said to be semi-stuporous, with limited responses but was oriented in all three spheres. He was weak and hypotonic, without lateralizing signs. There was some question of whether he might have some loss of gaze to the left and that his left eye might questionably be rotated outward. The visual fields were full, but the optic discs were not well visualized. He appeared to have pain in the frontal and retro-orbital area, but his neck was not stiff.

LABORATORY FINDINGS

"Laboratory data revealed a hematocrit of 51 per cent and a white count of 13,700 with increased polys. The sed rate and VDRL were normal. The BUN was 89 mg. per cent. No creatinine apparently was run. Electrolytes revealed an elevation of the CO_2 to 35.5 mEq./L. However, the chloride, potassium, and sodium were normal. A lumbar puncture was done, and the pressure was said to be "elevated," but apparently it wasn't measured. I don't know how the operator determined that the pressure was elevated unless maybe the fluid hit the wall behind him when he pulled the stylet out. The spinal fluid pressure is most important and should always be measured. The fluid was clear. The protein was 74 mg. per cent, and there were 2 lymphocytes present. An EKG showed left ventricular hypertrophy.

"Skull x-rays were reported as being normal. A brain scan was done which was said not to be satisfactory, but there was some question of increased activity on the right. A carotid arteriogram was done apparently to rule out the possibility of a subdural hematoma, but none was

found, and no aneurysm, vascular displacement, or tumor stain were noted. There was some question of slight avascularity high in the right hemisphere. A vertebral artery study was not done, and a chest x-ray was unrevealing. May we see the x-rays now, please?"

X-RAY FINDINGS

Dr. Ottis G. Ball: "A standard PA film of the chest was not obtained. A film was made for rib detail, in which you can obviously see a rather marked degree of generalized pulmonary emphysema. The heart is not enlarged. The aorta is a little tortuous. So about the only thing we see on this film is generalized pulmonary emphysema. He also had an IVP which revealed a somewhat small, poorly functioning, right kidney. There is some calcification in the paravertebral area, thought to represent calcification within the abdominal aorta, indicating it to be either tortuous and uncoiled, or aneurysmally dilated; a request was made for a lateral film to investigate this possibility, but this was not obtained.

"The brain scan revealed a relative increase in activity over the right periphery, but this was felt to be most likely due to a degree of rotation of the patient's head in the PA projection, although it is somewhat difficult to rule out an abnormality such as a subdural hematoma. The lateral scan was normal. An AP scan was not performed, apparently due to the patient's poor condition. I think the brain scan can be diagnosed as normal.

"A bilateral carotid arteriogram revealed no specific abnormalities. The anterior cerebral vessels were midline, and the middle cerebral complexes were normal, with branches extending out to the inner table of the calvarium, which rules out a subdural hematoma. When you compare the right and left sides there is some suggestion of a little avascularity in the right peripartietal region, but this too is somewhat equivocal, and it is felt that the carotid arteriogram is most likely within normal limits."

Dr. Bowlus: "I think we picked up some pearls during that. The patient was started on Rauwiloid by mouth and given Serpasil by injection, but his blood pressure remained elevated. The day after admission his temperature went up to 101.8 degrees rectally, and by the third day was 101 degrees. His pulse went up to 120-150 and was weak, and his hypertension remained unchanged. His respiration was 28 per minute, and he began to develop a problem with bronchial secretions; he was started on antibiotics. He was thought at times to move the right extremities more than he did the left, but the level of consciousness remained unchanged. His urinary output was good, and his pulse slowed to between 90 and 120 after digitalization. On the fourth day, his temperature remained elevated in the range of up to 102.6 degrees, but then later in the day his blood pressure dropped to 100/60; his pulse rate varied from 88 to 138, and became irregular; he became cold. Vasopressors were started, but he expired on the fifth day, apparently dying of shock.

"In summary, then, we have a 66-year-old man with a long history of hypertension, emphysema and headaches, who, in the past week, had gradually become unable to walk, with increasing drowsiness and vomiting, but without other neurologic complaints. On examination he was hypertensive, with enlarged prostate, and semi-stuporous, without localizing signs. Laboratory data showed only an elevation of the BUN and slight elevation of the CO_2. Spinal fluid protein and pressure were elevated. His course was downhill, terminating in shock.

DIFFERENTIAL DIAGNOSIS

"The differential diagnosis in this case, then, involves headache, hypertension, somnolence, inability to walk, elevated spinal fluid pressure and protein, without localizing neurologic signs. That covers a great deal. Essentially, we can develop his neurologic differential into four main categories: (1) Those due to lesions above the tentorium or supratentorial mass lesions; (2) subtentorial mass lesions; (3) metabolic or diffuse cerebral involvement; and, (4) cord involvement producing leg weakness. We'll mention a few of these possibilities briefly.

"It would seem that epidural hematoma, subdural hematoma, and intracerebral hematoma were fairly well ruled out by the normal carotid arteriogram. The possibility of cerebral infarction remains; however, again, we don't have enough localizing neurologic findings to make this diagnosis. Another possibility is a brain tumor, either primary or metastatic, in the silent area of the brain, that is, the posterior parietal, or even the occipital regions, producing no focal signs, but resulting in drowsiness and increased pressure and protein. It was said that his prostate was enlarged and firm, and I guess the possibility of prostatic carcinoma has to be entertained. This rarely metastasizes to the brain, but we have to

remember that this is a CPC and it might be one of the rare occasions.

"Another possibility of a supratentorial mass lesion which we would have to consider strongly would be a brain abscess in the silent area of the brain, again in posterior parietal and occipital regions. You can have a lot of involvement in these areas with a drowsy patient and not be able to pick it up. He did have elevated pressure. He suffered chronic lung disease, and we know these patients are very prone to develop brain abscesses. He was febrile, and there was a questionably avascular area on brain scan. A brain abscess would more likely produce an avascular area than would a tumor. Usually most tumors that are vascular will produce a stain when the arteriogram is done. So, these two possibilities would be the most likely of the supratentorial lesions.

"Essentially the same differential could go for those areas below the tentorium. In this case, I would most strongly consider abscess or infarction. However, usually if you get infarction in the brain stem you would have definite neurological findings, not vague ones as in this case. Now, infarct or hematoma in the cerebellum or even an abscess in the cerebellum would be very hard to pick up and could produce this increasing pressure without too much localizing signs. One other rare possibility is a subdural hematoma in the posterior fossa.

CEREBRAL DISORDERS

"The third grouping is that of metabolic and diffuse cerebral disorders, starting out with ischemic anoxia of the cerebrum, and, of course, with this degree of hypertension we have to consider the possibility of hypertensive encephalopathy. Now, this usually can take two courses, either a rapidly progressive course in which the patients rapidly go into a delirium, stupor, and coma, developing many focal seizures, or a more slowly developing course in which the patients might have generalized or focal seizures, with headache, vomiting, and multifocal neurologic weakness, or even cortical blindness. Neurologic signs here may last anywhere from a few minutes to a few days and then clear completely with prompt treatment. Usually a funduscopic exam shows hemorrhages, exudates, arterial spasms and papilledema. Of course, we don't know what his eyegrounds had. The CSF pressure in hypertensive encephalopathy is elevated, as is the spinal fluid protein, and usually there is a moderate degree of uremia, which this patient had, but usually the BUN is less than 100 mg. per cent.

"Another type of anoxia would be true anoxic anoxia or that associated with pulmonary disease, such as emphysema, multiple small pulmonary emboli, or hypoventilation syndrome. The cerebral symptoms are usually due to carbon dioxide retention, serum acidosis, and hypoxia, and usually consist of diffuse headache with drowsiness, stupor, and coma. The PCO_2, of course, is increased, they usually become cyanotic, and about 10 per cent have papilledema. They frequently develop asterixis and multifocal myoclonus. The deep tendon reflexes are frequently depressed, but Babinski's sign may be present. The blood gases are always abnormal. Now, the chronic lung disease that this patient had would account, I think, for his chronic headaches. Such patients frequently have these frontotemporal, persistent headaches, and I don't think that he has had some intracerebral disease, which has been going on for several years, that produced his terminal episode.

OTHER DISORDERS

"There are other diffuse cerebral disorders: that of concussion or postictal states, which we can rule out in this patient; infection, such as meningitis and encephalitis, whether it's viral, bacterial or fungal, but we have no indication of any of that in this patient; subarachnoid hemorrhage, which can be ruled out by the clear spinal fluid; exogenous toxins, poisons, or drugs, but we have no history in order to make that diagnosis; and endogenous toxic states, such as diabetic acidosis, uremia, hepatic coma, and hypoglycemia, or vitamin deficiency, such as Wernicke's encephalopathy, with progressive mental deterioration. I doubt that with the findings we have here we could make the diagnosis of uremia, and we certainly have no liver findings here to make the diagnosis of liver failure.

LEG WEAKNESS

"Then, we are left with the fourth group of causes of leg weakness and inability to walk. Here we have to think of causes below the head, those involving the spinal cord. It is possible that he could have had a metastatic lesion from the prostate compressing the cord, giving weakness of his legs, or he could have had a vascular occlusion of one of the cord arteries, or even a transverse myelitis. However, since Dr. Ball gave us this information about his abdominal

aorta, we now would have to consider very high on the list a dissecting thoracic aneurysm, or an abdominal atherosclerotic aneurysm. In this you can get the findings of a transverse myelitis. However, the last patient that I saw with this, about a month ago, had only leg weakness, and no sensory impairment or reflex change. Her legs were just flaccid, and there was no response to plantar stimulation or any other stimulus. Her symptoms had come on rather suddenly, with weakness of the legs.

"With progressive leg weakness in this case we have to consider aortic aneurysm; however, I would be more satisfied with this diagnosis if the weakness had come on very rapidly and if he had pain, or if there was some information in here on decreased peripheral pulses in the lower extremities. Apparently, with the blood pressure being what it was in the arms he had no involvement of the arch of the aorta. We would also like to be able to see something on the chest or abdominal x-ray. We do have that hint of a possibility there of abdominal aneurysm by x-ray, but pain was not in the picture, so there we are.

DIAGNOSTIC POSSIBILITIES

"After going through all this I still don't know what he had, and I'm not sure that I can even make a good guess. I think the possibility of an abscess in a silent area of the brain is a definite possibility in a patient with chronic lung disease, having increased spinal fluid pressure and protein, and this could either be in the posterior parietal or occipital region, or even in the cerebellum. If he had one, I'd put it on the right rather than the left. The other possibility is an aneurysm; he certainly did die in shock, and I guess it is possible that even without pain he could have had an aneurysm and had leg weakness and maybe hemorrhage. I think also the possibility of his dying from sepsis from his pulmonary infection and chronic lung disease as a terminal cause should be considered. So, I guess I'll take them in that order."

Dr. William B. Wilson: "Thank you, Dr. Bowlus, for an interesting discussion and an excellent analysis of this case. On opening the chest there was severe emphysema; in fact, I think the worst I have ever seen. The lungs literally ballooned out of the chest, and, when cut across, the cut surfaces almost resembled a spider-web, and then collapsed completely. The patient undoubtedly had extremely poor oxygen exchange with these lungs. I am sure there was CO_2 retention, also. He was never described as cyanotic, so we don't know how bad his oxygen exchange was. The brain showed microscopic edema consistent with hypertensive encephalopathy. The small arteries of the brain showed some sclerosis, and there were marked anoxic changes in neurons of the cerebellum and cerebrum. These anoxic changes were much more severe than one expects to see in uncomplicated hypertensive encephalopathy, and I think they were due to the patient's severe chronic lung disease with secondary hypoxia.

AUTOPSY FINDINGS

"When the abdomen was opened, there was found to be about two liters of blood in the retroperitoneal space, and a large ruptured atherosclerotic aneurysm of the abdominal aorta. The aorta was markedly atherosclerotic throughout its course, and it was impossible really to see the exit of any of the small vessels. The lumens of the larger branches of the aorta were markedly compromised by this extensive atherosclerosis. There was a layered, well-organized clot filling the aneurysm and partially occluding the abdominal aorta below the renal arteries, at the level of the exit of the lumbar arteries which supply the spinal cord. Apparently, the layering of the clot and the atherosclerosis occluded the lumbar arteries, causing vascular insufficiency of the spinal cord and causing the patient's symptoms of inabliity to walk. The iliac arteries were not occluded. The renal arteries also showed marked atherosclerosis, probably accounting for the hypertension and findings on IVP.

ABDOMINAL ANEURYSM

"This case was presented primarily because of the unusual symptom of leg weakness as a presenting sign of abdominal atherosclerotic aneurysm. Vascular insufficiency of the spinal cord is a well-recognized complication of dissecting thoracic aneurysms of the aorta, but apparently a rare complication of atherosclerotic abdominal aneurysms unless the aorta becomes thrombosed.[1] The blood supply of the spinal cord is characterized by excellent collateral circulation, both via paired vessels from the opposite side, and longitudinal collateral along the anterior spinal artery, thus necessitating extensive occlusion of the aorta or its branches before spinal cord ischemia develops.

"A recent article[2] gives an excellent summary

of the anatomical variations of the blood supply of the lower spinal cord and filum terminale, which serve to explain why some patients with atherosclerotic or thrombotic disease of the abdominal aorta are more likely to develop spinal cord ischemia than others. While the main source of blood to the cord is the anterior spinal artery, which is longitudinally directed and thus independent of segmental disease of the aorta, an important collateral vessel supplying the lower cord is the arteria radicularis magna anterior, which originates from a lower thoracic intercostal artery in 50 per cent of cases, and from a lumbar artery, below the diaphragm, in the other 50 per cent. When the latter situation exists, the blood supply of the spinal cord is more vulnerable to disease of the abdominal aorta, especially during surgery. This article also says that when ischemia of the cord does develop, it is usually due to the basic disease process plus superimposed acute hypotension, resulting from leakage or rupture of the aneurysm, or from surgery.[2] It has recently been emphasized that the combination of acute renal insufficiency plus acute motor weakness of the lower extremities, especially in elderly persons, or following trauma, should suggest occlusion or damage of the abdominal aorta, involving the blood supplies to the kidneys and lower spinal cord, and constituting an indication for immediate aortography.[3]

"Many atherosclerotic abdominal aneurysms, of course, remain asymptomatic until they rupture. Once rupture has occurred, the surgical mortality is much higher. When symptoms occur, they are likely to consist of intermittent claudication, back pain due to vertebral erosion, pain which may resemble renal colic, lumbar root pain, or attacks of ileus and distention due to mesenteric vascular insufficiency.[4] To this list, we may add signs and symptoms of spinal cord ischemia, usually consisting of motor paralysis, absent tendon and plantar reflexes, and perhaps sensory changes. Such findings, when they occur, are doubly important, since they suggest grave complications of the aortic disease, such as thrombosis or rupture, and may become irreversible, if emergency surgery is not done." ★★★

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SEASONAL CHANGES

The Florida tourist said to the hotel manager, "The weather here is so wonderful, how do you tell summer from winter?"

He answered, "In winter we get Cadillacs, Continentals, and stuffed shirts. But summer, we get Fords, Chevrolets and stuffed shorts."

Radiologic Seminar XC: Intracranial Arteriovenous Malformations

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MANY TIMES A-V malformations produce clinical signs and symptoms. Convulsions, neurological deficits and sometimes acute clinical problems are seen following an intracerebral hemorrhage resulting from bleeding. These lesions are less frequent and the bleeding more benign than its counterpart, the arterial aneurysms. It is probable that A-V malformations grow over a period of time at an unpredictable rate. Several such cases have been documented in the literature.

The radiographic diagnosis of intracranial A-V malformation is dependent on the plain skull films, carotid angiography and isotope brain scans.

Arteriovenous malformations may exhibit in the skull films linear, sometimes parallel calcium shadows but more typically numerous small punctate calcifications with lacelike appearance are seen. The linear calcifications are usually present in the blood vessels while the punctate deposits are in adjacent atrophic brain. Figure I demonstrates this stippled typical appearance. The amount of stippled calcification seen in no way reflects the extent of the vascular malformation.

Wide, tortuous vascular channels are sometimes seen in the skull film resulting from an arteriovenous shunt, producing increased blood flow.

Angiographically, arteriovenous malformations present several varied appearances. The most classical example is the A-V malformation with extremely rapid circulation time. Large draining veins are seen immediately after the injection of contrast media and the feeding arteries are enlarged and tortuous. The actual anomaly or "capillary portion" is mostly obscured by the dramatic pattern of tortuous feeding arteries and the large draining veins. Figure 2 is an example of the classical arteriovenous malformation with a rapid circulation time.

Another group of A-V malformations present only a slight to moderate increase in speed of circulation. Sometimes only a single small drain-



Figure 1. Demonstrates the punctate stippled pattern of calcification in the fronto-parietal region. Some bone erosion of the sphenoid is also seen.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Hospital.

ing vein is seen and it is relatively easy to overlook this pattern unless proper sequence films are obtained. In this group are included the "cryptic" A-V malformations (Russell 1954). These may bleed easily and produce intracerebral hematomas or fatal hemorrhages into the ventricles.

Vascular malformations without increase in speed of circulation would include 1) A-V malformation, 2) Sturge-Weber disease, 3) venous angiomas, and 4) cavernous angioma. The pattern of abnormality seen in this group is present in the venous phase of the study. Large veins coursing in unusual directions on the surface of the brain or within the substance of the brain are always abnormal and present a diagnostic pattern.

In order to demonstrate the true nature and extent of the intracranial arteriovenous malformation by angiography, rapid serial filming is necessary and sometimes films of six per second are necessary to demonstrate the actual capillary portion of the lesions. Examination of the contralateral side with contrast media must be performed routinely to demonstrate the extent, location, and vascular supply of the lesion. It is also important to rule out the possibility of other intracranial arteriovenous malformations as well as malformations in other regions of the body such as the pulmonary circulation since more than one malformation is sometimes present.

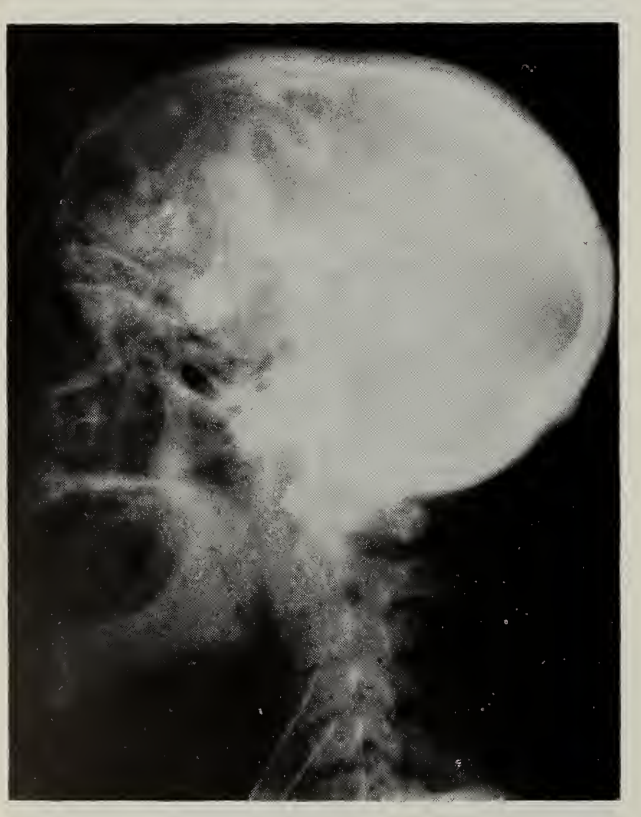


Figure 2. This demonstrates the classical angiographic pattern of an A-V malformation. The tortuous feeding arteries and the large dilated veins are well demonstrated and in this single projection obscure the capillary portion.

While contrast cerebral angiography is the definitive diagnostic procedure, brain scanning with Technetium-99^{m} and the scintillation camera now offers an easy method of screening and evaluation. It is possible to study the brain with serial scintiphotography utilizing the scintillation camera and the short-lived radionuclide Technetium-99^{m} (Tc99^{m}). Such a dynamic approach is expected to substantially increase the diagnostic accuracy in brain scanning. Serial rapid views obtained immediately after a bolus of Tc99^{m} is injected offers further information as to the nature of the vascular characteristics of brain lesions. Through the use of this approach three types of lesions are demonstrated on the brain scan.

Type I lesions (regressive) is characterized by maximum isotope uptake in the earlier phase followed by a gradual decrease. Meningiomas, arteriovenous anomalies and hemangiomas belong to this type. In type II lesions (progressive) the focus becomes progressively more dense, and is observed in gliomas, cerebral infarcts, abscesses and metastatic carcinomas. Type III lesions are cold focuses and are seen in intracerebral hematomas and cystic lesions.

From studies in the literature it seems that the regressive pattern of uptake seen with arteriovenous malformations depends primarily on the increased blood pool in the focus and not necessarily on the pathology of the lesion. The vascularity and blood flow in the focus are the important factors in determining the time course observed in the Tc99^{m} serial scanning, and it stands to reason that A-V malformations are a regressive type on the scan.

Figure 3 illustrates the classical pattern of an A-V malformation as seen with rapid serial views using the scintillation camera and a bolus injection of Technetium-99^{m}. Figure 3 is taken at 3 minutes in the earlier phase of the scan and shows the maximum uptake. Serial scans were obtained at intervals of 3, 6, 9, 12, 15 and 30 minutes. Figure 4 was taken at 9 minutes and reveals regression of the uptake as compared with the earlier scan.

This scanning technique may prove to be a very worthwhile tool for better evaluation and study of intracranial lesions.



Figure 3. This 3 minute scan using the scintillation camera and Technetium-99^{m} shows the maximum uptake in the malformation.



Figure 4. Scan taken at 9 minutes shows less uptake than the previous 3 minute scan and demonstrates the regressive type uptake of the malformation.

SUMMARY

1. Intracranial arteriovenous malformations are important radiological lesions and are demonstrated in various ways.

2. Plain skull films classically may show punctate calcifications with a lacelike pattern in the atrophic brain around the lesion.

3. The cerebral angiogram is the most definitive diagnostic procedure and classically shows tortuous feeding arteries and large draining veins due to the rapid circulation time.

4. Serial scintiphotography utilizing the scintillation camera and Technetium-99^{m} (Tc99^{m}) is proving to be a very useful diagnostic tool. The classical A-V malformation shows a regressive uptake pattern in that the maximum isotope uptake is seen early in the study and decreases throughout the remainder of the study. ★★★

2500 North State Street (39216)

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OFFICE FULL

"I'm sorry," said the dentist to a patient on the phone, "but I can't see you today. I have 18 cavities to fill this afternoon." Then he hung up, picked up his golf bag and left the office.



The President Speaking

'Supply and Demand'

JAMES L. ROYALS, M.D.
Jackson, Mississippi

In 1965, when Medicare became the law of the land, we wondered what effect it would have on American medicine. No one really knew what influence it would bring to bear on the providers of health care service. Even now, four years later, the extent of the change cannot yet be fully assessed. It can be said, however, that Medicare has brought an enormous increase in demand for medical service.

Medicaid has now been added to the law. And as Mississippi, under pressure of a time clock, seeks to implement it, we again wonder what effect this new law will have on Mississippi medicine. No one really knows. I think it is safe to assume that, among other things, it will give rise to yet another increase in demand for medical service.

In Mississippi we have the lowest ratio of physicians to population of any state in the nation. We have 78 physicians engaged in patient care per 100,000 people, compared to a national average of 135 physicians per 100,000 people. Many efforts are being made to improve this ratio.

The Mississippi health care team, shorthanded though it is, must prepare to meet with excellence the increasing demand for service. In addition, we must be aggressive in providing leadership that will bring good medical care to all our people. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME X, NUMBER 12

December 1969

EDITORIALS

Gnats and Camels: A Matter of Reasonableness

I

STRAINING AT A GNAT and swallowing a camel is no feat at all for government-supported medical care financing mechanisms, and the Social Security Administration has got to have a camel-lined stomach. In less than three years, SSA has literally tossed aside its own groundrules for paying for professional services under Part 1-A of Medicare. Now, its own catcher is calling the fouls on the hitter.

Nor is Medicaid much different, under HEW edicts which freeze, circumscribe, confuse, and perplex the practitioner upon whose shoulders fall the task of furnishing the care contemplated in the law. If indeed the laborer is worthy of his hire, the time is past to do something about these problems in the interest of simple equity.

On the one hand, the government pays hospitals on a cost basis. This is based on the assumption that the institution's charges are documented on the books with so much spent for labor, supplies, utilities, food, and all the rest. On the other hand, government says that physicians are paid on a charge basis, meaning that there is literally no documentation for the fee other than a value placed on the services by the practitioner. Within this central issue are found the elements which make it hard to get at the gnats while bolting down the camels. In a nutshell, there is a need to be reasonable about reasonable fees.

II

A vast and overwhelming majority in American medicine are sincere and realistic about professional compensation, recognizing readily that there is a bottom to the bucket. For many years, medical organization has deplored the infrequent and unpleasant circumstance of aberrant charges which, in the eyes of peers, were excessive. The private care delivery system works because it is responsible and realistic, and nothing in this series of observations should be construed as a clarion call for blue sky charges for professional services.

If the policy actions of the houses of delegates of AMA and the several state medical associations may be taken at face value, a majority in American medicine believes in and supports a pluralistic delivery system which offers more than one means of care financing. In this context, these observations are not therefore intended as an attack upon any aspect of the system.

So it isn't an oversimplification to say that physicians want a care financing system which works for care delivery—not one for which they have to work.

But under Medicare, we are encountering examples of limiting both the quantity and quality of medical care through restrictive SSA policies and regulations. In the final analysis, the amount of care necessary for the patient is a medical decision. If such a decision appears to be in error or irregular in any manner, then it is an appropriate matter for peer review or consideration by other physicians. Nonphysicians, however well informed, are not competent to judge medical need.

III

The long term patient, so frequently encountered among the aged, presents a problem to the Social Security financing mechanism. While the law clearly provides for 90 days of hospitalization per spell of illness, those who administer Part 1-B pick and bicker over amounts and degree of medical services in these cases.

Where the utilization review function, a medical matter for medical men and women, is properly carried out and where there is sufficient physician documentation of the case, there can and should be no argument. The same reasonable criteria must also be applied to patients in extended care facilities.

Arbitrary limitations upon professional services based solely upon means, medians, modes, and whims are neither scientific nor just. Again, medical review by peers is the answer. Nobody denies for a moment that any program is not subject to abuse, and medical organization takes this into account with peer review.

Just as the honest employee with a fiduciary responsibility welcomes bonding, so does that vast majority of American physicians welcome peer review of which, incidentally, they are an integral part.

IV

And then there are the fee profiles, a subject likely to bring groans and growls when considered in the Medicare context. Initially, Medicare regulations provided for profiles giving information on the range of fees in a medical community or socioeconomic area. Thus, a fee charged might be judged in comparison with those prevailing in the same area. Consideration could be given to amount of service, demand upon the practitioner, elements of difficulty and skill involved, and other aspects and components of the charge.

In fact, the original SSA regulations provided for meeting the 90th percentile of charges, meaning the top of the range charged by 90 out of 100 physicians.

In December 1968, the then-Secretary of Health, Education, and Welfare decreed not only a freeze on fees but a freeze on individual physician charges. Most Part 1-B carriers had by then adopted the practice of keeping profiles by individual physician, casting aside the original concept of the medical community. This is not a profile but rather a maximum fee schedule.

AMA has denounced this practice, adopting a resolution at its 1966 annual convention which declared that "the American Medical Association continue to insist that the Social Security Administration observe its intent, as expressed to carriers, to use code numbers only in such manner as necessary to accommodate to machine processing and, in no instance, change these instructions to any degree which will permit the identification of an individual physician in the files of a central agency."

For all the folderol, the gnat gets smaller and the camel bigger under Medicaid which also has come under severe restriction: Medical fees may be held to the 75th percentile and in many instances, states have set them even lower. Such is apparently the case in Mississippi where the maximum payable is the benefit in the Blue Shield F-300 schedule. It, as is true of most Blue



Shield maximum fee schedules, has little semblance of relativity among procedures. The Mississippi Medicaid Commission staff readily conceded this.

And of all state and federal monies paid out under Medicaid in every state with a program since its inception in 1966, *only 11 per cent has been paid to physicians.* The other 89 per cent goes to hospitals, nursing homes, and other providers.

There is a moral in the story, and it's not how easily camels can be swallowed by bureaucrats. The moral is, in the words of President James L. Royals, for government care financing mechanisms to place responsibility for usual, customary, and reasonable fee determination upon peer review mechanisms in medical societies and for physicians to prove themselves worthy in the discharge of this responsibility to have their judgments accepted.—R.B.K.

Priceless Service By Meridian Physicians

In adversity and tragedy, man can and on occasion does rise above personal distress and discomfort to give in generous measure to the comfort and succor of others. No Mississippian has to be reminded that hundreds of such selfless acts are documented during the dark days of Hurricane Camille on the Gulf Coast.

Praise for such acts came from our governor, John Bell Williams, from Vice President Agnew, and even from President Nixon. The Most Rev. Fulton J. Sheen, the distinguished and respected Catholic prelate, said that this was the first time he had observed "the victims becoming the helpers."

But there were countless others who gave more than a nominal measure of service, and the physicians of Meridian are at the top of that honor roll. Immediately following the hurricane strike, it was decided to evacuate 123 patients from two nursing homes in the Pass Christian area. In fact, the Mississippi State Medical Association was asked to coordinate the operation which involved a three-flight airlift on Aug. 21. The Mississippi Hospital Association found that the six hospitals and three nursing homes at Meridian had the necessary available beds, and the Meridian institutions generously opened their doors—and hearts—to the storm victims.

The administrator of the Jeff Anderson Hospital, Mr. Reuben Johnson, served as coordinator in the near-record handling of disaster victims, assigning each of the 123 to one of the nine participating institutions. In turn, each chief of staff assigned attending physicians to the patients. All told, some of these patients were institutionalized for seven weeks before being returned to Pass Christian.

Thirty-eight Meridian physicians cared for the 123 patients over a period of 43 days. These valuable services were given without remuneration in the finest and highest traditions of medicine.

And a word is in order about the allied professionals on the Meridian health care team, too. Nurses, technologists, aides, and others gave in full measure, working long hours, especially when these malnourished and largely uncared for victims of the storm were first admitted.

Neither the first nor the last act of high service, the work of Meridian physicians stands high among Mississippians who cared about the ravages of this terrible storm to their fellow man. —R.B.K.

Tougher Taxes for American Medicine

The Senate Finance Committee cannot be fairly described as a physicians' fan club. The chairman, Sen. Russell Long (D., La.), has been busily tightening up the provisions of the House-passed tax reform bill in a discriminatory manner, at least as far as physicians are concerned.

Targets for the stern measures being written into the bill are both M.D.'s and their medical organizations. At the end of the month, the committee stated that "the bill does not presently deal with the limits of pension plans except to provide that small business corporations (so-called Subchapter S corporations) must in the future follow in general the limitations of H.R. 10 (Keogh) plans."

Then Sen. Long's group lowered the boom by stating that "the committee decided to impose essentially the same limitations upon pension plans of professional service corporations (relating to doctors and attorneys under special state laws)."

If enacted by the Congress, this would literally wipe out tax benefits of professional service corporations. Earlier in the year when the Treasury Department and Internal Revenue Service announced that they would no longer contest tax eligibility of professional service corporations established under state law, many observers took

the statement with a grain of salt. It was unlikely, they noted, that IRS and Treasury were suddenly given to any degree of generosity. Now, the tax provision seems to confirm this only too clearly.

That the provision of the bill is discriminatory against self-employed professional individuals is almost rhetorical. The small businessman, meaning the Ford dealer, the barber, the store owner, and even the farmer, may still provide for his retirement with tax-free benefits, but not the physician or the attorney.

Second, Sen. Long has decided that Big Brother isn't watching physicians closely enough. He has written a provision into the new tax bill requiring Part 1-B Medicare carriers and Medicaid fiscal administrators to report the names and amount of earning of all physicians participating to the Internal Revenue Service. Furthermore, their names and Social Security numbers are to be reported to HEW which is, in turn, required to report by name any physician earning $25,000 or more annually to the Congress.

Finally, the tax-by-regulation on advertising in scientific journals is being written into law so that AMA and every state medical association will have a new and heavy tax liability.

It is evident that Sen. Long understands all too well the views of Chief Justice Marshall who said more than a century ago that "the power to tax is the power to destroy."—R.B.K.

CHAMPUS: An M.D.-Managed Care Plan

In 1970, the Department of Defense has ordered significant procedural changes in the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) drug program. At the outset, it should be noted that CHAMPUS is the only program with across-the-board prescription drugs for its beneficiaries on an outpatient basis. Medicare has none, and since Medicaid isn't truly "national" until every state adopts and implements it, CHAMPUS stands alone in this pioneering service.

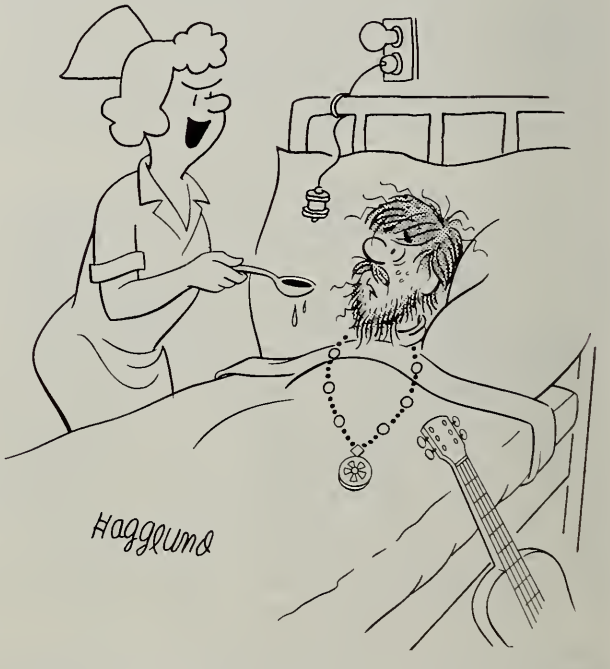
The change will not affect or bother the physician in the slightest, thanks to a wise decision by the Department of Defense. The physician, as with all his patients, merely writes his prescription. There are no special or additional forms for him to complete or even see.

The pharmacist (of the patient's choice) does the paperwork which is minimal, about half a page. The patient co-pays by participating up to 25 per cent in the cost of the Rx, which most physicians view as a good policy.

It is refreshing and encouraging to observe that the Department of Defense, while watching the tax dollars which go into this program, recognize professional prerogative which goes with professional responsibility: The physician is free to choose his patient's prescription either generically or by brand name. In this day of compulsory generic prescribing under some programs, circumscribing formularies, and all sorts of restrictions about who shall receive what drugs, we salute the Department of Defense for obviously understanding that quality medical care depends upon professional judgment.

There are no data to suggest that costs of caring for CHAMPUS patients are as much as other tax-supported programs, either.

To be sure, CHAMPUS has had its problems and rough spots. When the program was expanded a couple of years ago to include the retired and full outpatient services, everybody was caught short, because the Congress acted quickly and without providing a tool-up period. But fiscal administrators have bridged this growth gap, and in Mississippi, a clean claim—meaning one which is complete on initial receipt—is paid in two to 10 days.



"Take your medicine or I'll give you a bath!"

On Dec. 7, the CHAMPUS program will be 13 years old. It has worked well, depended upon peer review by physicians, and come nearer than any other national tax-supported medical care plan to meeting the going rate of medical care costs. It is probably unique in that it is run from top to bottom by physicians, its chief being the Army Surgeon General and its executive director, a physician who is also a general officer. Let it be hoped that this constructive forward thrust may be continued and strengthened. —R.B.K.

On Becoming 10 Years of Age

Almost nobody would notice, in the absence of this reminder, that the JOURNAL is 10 years old with this issue. At the 91st Annual Session in 1959, the House of Delegates made the decision to publish an association-owned periodical, and the first issue appeared in January 1960.

Two things characterize the JOURNAL: It is a team project and it belongs to the membership. As the largest and most substantial continuing endeavor of the association, the JOURNAL eats up manhours of the Editors, a six member committee, and a staff team—over and above the dozens of physician-authors who publish each year. Nor are these contributors limited to those submitting major scientific papers, because many valuable contributions are made in literature reviews, letters to the Editors, and in solid work which is never set into type.

Still another essential member of the team is really another complete team, The Ovid Bell Press, Inc., our printers. This major printing house produces more than 40 journals and magazines along with about 100 books a year. Its skilled corps of compositors, pressmen, proofreaders, binders, and management translate into paper and ink the ideas, designs, and thinking of authors and Editors. They make a huge task in logistics and the graphic arts seem easy.

Since this is a special occasion, a little liberty is being taken: The first person is being used for the first time in a JOURNAL editorial. As managing editor, I (your JOURNAL's style book omits the imperious Victorian "we" usually employed by editorial writers) owe a double measure of thanks to the association's leadership for making the JOURNAL possible. From the president and Board of Trustees down to the newest junior staff member, many work each day for the JOURNAL.

Unlike some medical journal organizations, our Editors are not compensated for their services, yet they give generously in guiding the destinies of the book, in editing and reviewing manuscripts, and in making the decisions. The Committee on Publications carries great responsibility (the JOURNAL has been a gross operation of about $1 million during its first decade of life), rendering its stewardship accounting to the Board of Trustees officially and to the membership monthly in the pages of the book.

The staff team includes every member except those in the Department of Medical Care Plans (CHAMPUS). In the JOURNAL Department, two fine young women with three degrees in journalism between them, carry out their tasks superbly. The membership director handles the tricky tasks of circulation among Mississippi physicians and writes three monthly features. The Data Processing Department gives close attention to nonphysician subscribers, billing for advertising, and monthly analyses of costs, while the executive assistant presides over accounting and fiscal records.

The Board of Trustees and general officers give hours at meetings considering with patience and understanding the JOURNAL's performance and needs. And the State Medical Journal Group with offices in Chicago, New York, and on the West Coast knocks on the doors of top management in the pharmaceutical industry to sell our pages.

So with this decennial issue—as with each issue—a team of about 20 physician-leaders and staff members, half a dozen authors and contributors, a major printing house, half a hundred advertisers, advertising representatives working coast to coast, and the association's elected leadership worked an average of 12 man hours per page to bring out this issue.

This is the story of one characteristic, the team. The other is that you, the member, own the entire operation and have the final say-so about your JOURNAL. Give us your wishes, your ideas, and especially your contributions in papers and articles. As a general interest scientific publication, your JOURNAL cannot and does not try to compete with national books or the specialty publications. It is your forum and hopefully, your best and most complete news source on Mississippi medicine.

The JOURNAL has reached its 10th birthday only because the real owners, the membership, willed it so. We (there goes that imperious first person plural) hope to live to be 100!—R.B.K.

POSTGRADUATE CALENDAR

December 4, 1969

DERMATOLOGY SEMINAR

University Medical Center, Jackson
December 4, 1969, beginning at 9:30 a.m.

Sponsored by the University of Mississippi School of Medicine Postgraduate Education Committee and the Division of Dermatology, Department of Medicine.

Participants:

Charles W. Caccamise, M.D., clinical assistant professor of medicine (dermatology), The University of Mississippi School of Medicine

Lucy Lawson, M.S., assistant professor of microbiology, The University of Mississippi School of Medicine

James G. Thompson, M.D., clinical professor of medicine; chief, division of dermatology; and seminar coordinator, The University of Mississippi School of Medicine

Louis J. Wise, M.D., clinical assistant professor of medicine (dermatology), The University of Mississippi School of Medicine

This all-day seminar, designed for the physician in general practice, will include lectures and panel-audience discussions. Topics will be contact dermatitis, papulo squamous eruptions, warts and other viral diseases, office diagnosis of fungal disease, acne vulgaris, lymphoma, and cutaneous manifestations of internal disease. Advance registration, tuition-free, is requested.

FUTURE CALENDAR

November 13, 1969
Current Concepts of Gynecologic Cancer

November 18
Circuit Course, Tupelo

December 4
Dermatology Seminar

January 6, 1970
Circuit Course, McComb

January 8
Circuit Course, Hattiesburg

January 19-23
Cancer Chemotherapy Intensive Course

January 27
Circuit Course, Columbus

February 5
Circuit Course, Hattiesburg

February 9-13
Radiology Intensive Course

February 11
Seminar on Back Pain

February 17
Circuit Course, Natchez

February 24
Circuit Course, Columbus

March 2-6
Renal Disease Intensive Course

March 12
Circuit Course, Hattiesburg

March 16-20
Cardiology Intensive Course
Stroke Intensive Course

April 1-3
Cardiovascular Seminar

April 7
Circuit Course, McComb

April 16
Mississippi Thoracic Society, Jackson

April 21
Circuit Course, Columbus

May 11-14
Mississippi State Medical Association

PERSONALS

William Anderson, III, Joe Covington, E. E. Robinson and Wendell H. Cook, all of Meridian, participated in a panel discussion at the recent meeting of Meridian lawyers and physicians. About 85 persons attended the meeting at which mutual problems and better ways to cooperate to serve the public were discussed.

Esther G. Barry of Pascagoula announces the opening of her office in the Owl Shopping Center at 850 Chico Road. Dr. Barry limits her practice to infants and children.

L. Z. Broadus of Purvis was among five state physicians who participated in a refresher course on electrocardiography at the University Medical Center in Jackson.

Ralph Brock of McComb has been named chief of the medical staff of the Southwest Mississippi General Hospital for a year, from Oct. 1, 1969. Other members of the executive committee are Tom Mayer, vice chief of staff; Julian Janes, secretary; J. O. Wood, and Verner Holmes, immediate past chief of staff.

Theresa L. Buckley of Biloxi has been named to appear in the 1969 edition of *Who's Who in American Women.*

Hollis Burrow of Greenville gave the keynote address at the statewide Patriotic Education Week rally of the Children of the American Revolution.

P. Temple Carney, Meridian native, recently joined Robert L. Peede in the practice of family medicine at the Peede Clinic in Brandon.

John D. Coffey of Natchez was selected as Scouter of the Month for Adams County for September, 1969. He was honored for his many years of dedication to the youth of Natchez through the Scouting program.

Walter W. Crawford of Tylertown assumed the presidency of the Mississippi Academy of General Practice during its 21st scientific assembly at Biloxi. Also elected were: William Parker of Heidelburg, president-elect; William B. Hunt of Grenada, vice president; and John G. Atwood of Meridian, secretary-treasurer.

Thomas H. Gandy of Natchez was principal speaker at the banquet of the Fall Council meeting of District Three, Pilot International in Natchez.

Wendell N. Gilbert, Sr., announces the opening of his office for family practice at 109 School Street, Newton.

Bobby J. Heath has joined the family practice of Curtis D. Roberts at McLaurin Medical Center in Jackson.

Joseph R. Henry, formerly of the Air Force at Keesler, has retired from the service and has begun the practice of general surgery in New Albany with E. E. Bramlitt. Col. Henry received the high honor, the Legion of Merit Medal, on July 31 after nearly 29 years in the Air Force.

T. R. Howell has associated with W. B. White in offices in the Medical Arts Building at 1203 Jefferson Street, Laurel.

Calvin Hull of Jackson has been installed a member of the Board of Directors of the Evening Optimist Club.

Darcy G. Kobs, Jr. has joined Dan Reikes and Carl R. Hale of Hattiesburg in the practice of radiology.

Patrick Lehan, Jesse L. Wofford, and Guy D. Campbell, all of Jackson and UMC, recently addressed the first annual meeting of the Southern chapter of Cardio-pulmonary Technologists at Jackson's Sheraton Motor Inn.

L. L. McDougal, Jr., C. P. Tharp and M. M. Winkler, Jr., all of Tupelo, and associated in the Infants, Children and Adolescent Clinic, have announced their change of office hours to Mon.-Fri. 8 a.m. to 4:30 p.m. and Sat. 8 a.m. to 3 p.m.

W. L. McFarland and Henry A. Maggio, both of Bay St. Louis, have been appointed Medical Advisors for Local Board 24, Hancock County Selective Service System.

Wilford J. Patterson of Clinton announces the opening of his office in Clinton Plaza Shopping Center for the general practice of medicine.

Laura Peacock of Biloxi has been named to *Who's Who in American Women* in the latest edition. Dr. Peacock is a general practitioner at Keesler Air Force Base.

William E. Riecken of Jackson was elected section chairman for administration of the Mississippi Public Health Association at the 32nd annual convention.

Curtis D. Roberts of Jackson has become co-owner of the *Rankin County Press,* weekly newspaper of Brandon.

Robert Shell of Vicksburg was recently elected president of the West Mississippi Medical Society. Other new officers are M. E. Hinman, secretary-treasurer, and Chester Masterson, vice president.

James P. Spell of Jackson is currently serving as president of the Mississippi Division of the American Cancer Society. A. E. Brown of Columbus is president-elect of the organization.

David H. Strong, a native of Crosby, has associated with Frank C. Massengill of Brookhaven in the general practice of medicine at 203 W. Congress. Dr. Strong is a recent graduate of the University of Mississippi School of Medicine.

ROLAND B. TOMS of Jackson was recently awarded a 45-year service certificate and pin for his years of government service. Dr. Toms has been at the Jackson VA Center since July 1950.

R. B. TOWNES of Grenada spoke to the Grenada Bulldog Club recently on football injuries and preventive measures.

R. B. WARRINER, JR. of Corinth was honored at the October meeting of the Alabama-Mississippi Library Associations in Biloxi. He received an award for distinctive service as a Library Trustee.

ELBERT A. WHITE, III of Corinth has been elected president of the Kiwanis Club of that city.

REGINALD PACE WHITE of Meridian and East Mississippi State Hospital has been named to appear in the 1970 edition of *Who's Who in America.*

DEATHS

ADAMS, JOHN CHARLES, Greenwood. M.D., Tulane University School of Medicine, New Orleans, La., 1918; interned New Orleans Charity Hospital, La., one year; New York Postgraduate School, Jan. 1, 1920-Jan. 1, 1921; Emeritus member of MSMA; member of MSMA "Fifty Year Club"; died August 28, 1969, aged 82.

BANE, JOHN ROY, JR., Jackson. M.D., Tulane University School of Medicine, New Orleans, La., 1951; interned Baptist Memorial Hospital, Memphis, Tenn., one year; died Oct. 26, 1969, aged 44.

MCCANN, EZELLE, Batesville. M.D., Northwestern University Medical School, Chicago, Ill., 1920; interned Memphis General Hospital, one year; postgraduate study in Psychiatry at St. Elizabeth's Hospital, Washington, D. C., 1923; Pathology, Walter Reed General Hospital, 1928; Physical Medicine, V.A. Hospital, Hines, Ill., 1948; died Sept. 27, 1969, aged 84.

WINGO, MAURICE ROSS, Pass Christian. M.D., University of Texas Southwestern Medical School, Dallas, 1948; interned U. S. Marine Hospital, Cleveland, Ohio, one year; residency, Lafayette Charity Hospital, La., July 1, 1949-June 30, 1950; V.A. Hospital, New Orleans, La., July 1, 1957-June 30, 1959; radiology residency, Charity Hospital, New Orleans, La., July 1, 1958-June 30, 1959; died Oct. 25, 1969, aged 49.

Dr. David Wilson Named UMC Vice Chief

Dr. David B. Wilson has been named an assistant director of the University of Mississippi Medical Center in Jackson with special responsibility in health care planning, according to Dr. Robert E. Carter, director.



Dr. Wilson

Dr. Wilson had been director of the Medical Center's University Hospital since 1954, having been appointed to that position before the Center opened July 1, 1955. He assisted in planning the institution beginning in 1951.

Dr. Wilson's promotion to the newly created post was formally approved at the October meeting of the Board of Trustees, Institutions of Higher Learning, at Delta State College in Cleveland.

The Board also appointed D. Andrew Grimes acting director of the teaching hospital. He had been its associate director since 1967.

The immediate past-president of the American Hospital Association, Dr. Wilson is a commissioner on the Joint Commission on Accreditation of Hospitals, a member of the Board of Governors of the Blue Cross Association, and on the Medical Advisory Committee to the Department of Defense.

He is a past-president of the Mississippi Hospital Association, current president of the Jackson Rotary Club, a deacon in the First Presbyterian Church, and on the Jackson Chamber of Commerce Board of Directors.

"Dr. Wilson's new and additional responsibilities are in keeping with his extensive experience in hospital planning, organization of health care systems, and public health, all of which are urgently important in medicine today," Dr. Carter said in announcing the administrative change. "The Medical Center is singularly fortunate to have a staff member with Dr. Wilson's qualifications to assume this responsibility."

Book Reviews

Atlas of Precautionary Measures in General Surgery. By Ivan D. Baronofsky, M.D., Ph.D., Professor and Chairman, Department of Surgery, Hahneman Medical School, Philadelphia, Pa. 281 pages with illustrations. St. Louis: The C. V. Mosby Co., 1968. $23.50.

Dr. Baronofsky has compiled with his excellent medical illustrator, Miss Daisy Stillwell, a very outstanding text covering precautionary measures in general surgery. Dr. Baronofsky trained at University of Minnesota under Dr. Wangensteen and is now Professor of Surgery at Hahneman. The book covers the most common general surgery procedures both by his comments and by excellent illustrations by Miss Stillwell.

The author takes one step by step through each operative procedure as illustrated on the opposite page and gives his own methods and safeguards which he has developed over many years of surgical experience. Dr. Baronofsky's comments are excellent and undoubtedly reflect the thoughts of an experienced, wise surgeon. Miss Stillwell's illustrations clearly depict his points of discussion which make it very simple and clear.

It is interesting to read Dr. Baronofsky's comments on the various surgical procedures and the methods in which he handles the various complications. The operations he covers are: cholecystectomy, bile duct exploration, sphincterotomy, pancreatectomy, gastric resection, vagotomy, pyloroplasty, esophageal stricture, colon resection, rectum resection, ileostomy, colostomy, closure of colostomy, appendectomy, resection of Meckel's diverticulum, rectal prolapse repair, diaphragmatic hernia repair, inguinal hernia repair, ventral hernia repair, thyroidectomy, adrenalectomy, mastectomy, and finally, varicose veins stripping.

This book is of value to surgical residents as they are taught surgical techniques and, to the practicing general surgeon as it gives a refreshing new look at our most common general surgical procedures.

RICHARD J. FIELD, JR., M.D.

Handbook of Pediatric Medical Emergencies, Fourth Edition. By Charles Varga, M.D. St. Louis: The C. V. Mosby Company, 1968. $19.75.

The purpose of a handbook is its ability to be used as a quick reference. Charles Varga's *Handbook of Pediatric Medical Emergencies* accomplishes this purpose, but his compilation of materials is so refreshing that one has a desire to continue reading.

In addition to Varga, there are 13 contributors to this handbook of 18 chapters. These cover all conceivable emergencies in pediatrics. From any pattern of symptoms or critical situation one is able to develop a plan of management to meet the needs of most pressing conditions encountered in children. The realm of urgent diagnosis and treatment is covered from the different viewpoints of the physician and patient as well as from the viewpoints of the parent, ancillary medical personnel, school authorities and others committed to the care of children. An urgent situation in the eyes of the layman often differs from that of the physician, but competency in handling these matters often allays the frequent frustrations of a busy practice. Varga's philosophy of practice imparts an awareness of responsibility of the physician to his patient in terms of current practices and procedures. In addition, Varga reveals his sensitiveness by many carefully chosen quotations which augment the introduction to each chapter.

The chapter on emergencies in the newborn depicts the frequent pressing conditions which demand concern and prompt action from the physician. A stepwise procedure in resuscitation of the newborn, including directions for intubation, should be of interest to all concerned with this initial emergency of pediatrics.

Neurologic emergencies cover those conditions which so commonly confront the physician at inopportune times. Convulsions are discussed from home management to the most intensive care required in hospital management. Special consideration is devoted to etiological determinations. A concise plan for management and observation of patients with craniocerebral injuries should be comforting to the physician who feels

uneasy when compelled to care for the child with head injuries. Also important is the section on meningitis which details all necessary steps in establishing specific diagnosis and treatment.

A chapter on psychiatric emergencies is very informative and reassuring to anyone who feels inept in handling the child with suicidal tendencies, acute psychoses or anxieties.

Ophthalmologic emergencies are usually cases for quick referral by one in general practice for children. However, if one could follow the general principles of the ocular examinations, he should experience increased competency.

A chapter on pediatric procedures carefully describes in detail such procedures as various vein punctures, exchange transfusions, peritoneal dialysis and subdural taps.

About one fourth of the book is devoted to a section on poisoning which is very comprehensive in its coverage of a multitude of toxic elements. A numerical listing of symptoms and signs followed by treatment should make the book an invaluable reference to the pediatrician who is confronted almost daily with the child who has ingested potentially toxic substances.

In summary, Charles Varga has compiled a handbook which is extremely comprehensive in its coverage of the multitude of diseases and accidental conditions that commonly befall children. It should serve as an aid in establishing diagnoses where urgency demands accurate thinking.

HOWARD H. NICHOLS, M.D.



The following physicians have been elected to membership by their respective component Medical Societies in the Mississippi State Medical Association and the American Medical Association.

COLLINS, KENNETH, Greenwood. Born Calhoun County, Miss., April 21, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Brooke General Hospital, San Antonio, Tex., one year; pathology residency, University Medical Center, Jackson, Miss., July 1, 1965-June 30, 1969; elected Oct. 8, 1969 by Delta Medical Society.

LOVE, ROBERT TAYLOR, JR., Greenville. Born Greenville, Miss., March 19, 1937; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned South Pacific General Hospital, San Francisco, Calif., one year; general surgery residency, University of Arkansas, Little Rock; plastic surgery residency, University Medical Center, Jackson, Miss., July 1, 1967-June 30, 1969; elected Oct. 8, 1969 by Delta Medical Society.

MCAFEE, JAMES EARL, Cleveland. Born Dyersburg, Tenn., July 7, 1935; M.D., University of Tennessee College of Medicine, Memphis, 1963; interned St. Joseph Hospital, Memphis, one year; elected Oct. 8, 1969 by Delta Medical Society.

OWENS, WILLIAM FRANKLIN, JR., Jackson. Born Heflin, Ala., June 16, 1929; M.D., Tulane University School of Medicine, New Orleans, La., 1954; interned Philadelphia General Hospital, Philadelphia, Pa., one year; orthopedic surgery residency, Medical College of Georgia, Augusta, July 1, 1959-June 30, 1963; elected Aug. 5, 1969 by Central Medical Society.

STECKLER, DAVID ROBERT, Greenwood. Born Biloxi, Miss., March 4, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Mississippi Baptist Hospital, Jackson, one year; pathology residency, University Medical Center, Jackson, Miss., July 1, 1965-June 30, 1969; elected Oct. 8, 1969 by Delta Medical Society.

TALEFF, MICHAEL, Meridian. Born Pittsburgh, Pa., April 6, 1936; M.D., University of Pittsburgh School of Medicine, Pennsylvania, 1961; interned Presbyterian University Hospital, Pittsburgh, Pa., one year; internal medicine residency, same, July 1, 1962-June 30, 1963; ophthalmology residency, Cincinnati General Hospital, Ohio, July 1, 1966-June 30, 1969; elected Oct. 7, 1969 by East Mississippi Medical Society.

Society of Thoracic Surgeons to Meet

The Regency Hyatt House of Atlanta will be the setting for a meeting of the Society of Thoracic Surgeons Jan. 12-14, 1970.

Nationally and internationally known speakers will present papers on the newest developments in surgery of the heart, lungs and esophagus.

Guest registration for the meeting is $10.00. Interns and residents will be admitted without charge with a letter from the chief of the service.

Prior to the meeting, on Jan. 11, there will be a postgraduate course on cancer of the lung and on pacemakers. Fee is $10.00.

Ole Miss Medical Alumni House Nears Completion on Medical Center Campus

A March 1970 completion date is virtually guaranteed for the University of Mississippi Medical Alumni House on the medical center campus at Jackson. The spacious and modern building will add a new dimension to the center complex.

The three-story structure, costing just under $700,000, will offer 40 double rooms with two suites, food service and conference facilities, and headquarters for the medical alumni offices, according to C. W. Bill Price, alumni secretary at Jackson.

Sited on the University Medical Center campus north of the central complex of the school, hospital, and research building, the alumni house may be seen both from North State St. and Lakeland Drive.

The highly functional contemporary design features prestressed concrete columns on the exterior. These support steel joists and the concrete and steel-reinforced floors. A balcony-passage affords easy access to the bedrooms on the second and third floors which are served by elevators and stairs.

Price said that medical alumni offices will be on the first floor. Also located there are the lobby and registration desk, food service and preparation areas, conference facilities, hostess' apartment, and mechanical rooms. The building is air conditioned with a chilled water system which functions independently of the heating system, also a water unit.

The building was constructed with assistance from the State Building Commission and underwritten by Ole Miss medical alumni. It is expected to be self-ammortizing from room revenues, food sales, and other sources.

Price said that furnishings and equipment are being procured to assure installation by the March completion.





C. W. Bill Price, Ole Miss Medical Alumni Secretary, surveys interior progress to date on the third floor. The near $700,000 structure, located north of the central Medical Center complex, will offer 40 double rooms with two suites. Right, Price looks over the contemporary building exterior masonry and extensive parking facilities.

ORGANIZATION / Continued

Paved drives provide access from the UMC campus road system. Ample off-street parking surrounds the building with principal areas on the north aspect which is the front. Service entrance and delivery facilities are located on the south side.

The alumni house will be available to alumni, out-of-town visitors to the UMC campus and to physicians attending postgraduate training. It is expected that room rates will be competitive with motels of comparable quality and service.

Price said that the food services would be operated by the Vocational Rehabilitation for the Blind which is purchasing all new and modern restaurant equipment. Interior finishes will include masonry, paneling, and carpeting, Price said.

Addition Completion Is Slated This Month

Completion of the addition to the association's Central Office Headquarters Building at 735 Riverside Drive in Jackson is expected within the month, according to Drs. James L. Royals, association president, and Mal S. Riddell, Jr., Board chairman and chief of the building committee.

With major aspects of the construction completed in November, the interior trimming out was underway at press time for the JOURNAL.

Prior to Thanksgiving, the structural steel was complete along with exterior and interior masonry. Roof decking, a special corrugated metal sheeting, was in place and the lightweight concrete base poured. The roofing subcontractor completed the felt, tar, and crushed marble courses in good weather, Drs. Royals and Riddell said.

Interior finishing began with heating and cooling ductwork installation and placing of partitions within the structure. The design provides for clear span with no interior columns, the roof being supported by 20-inch steel I-beams.

Concomitantly with interior finish work, the mechanical and heating subcontractors are completing plumbing, heating, and air conditioning installations. Final work is scheduled on electrical service, including high intensity illumination in the windowless addition.

Site improvement work has also progressed with completion of concrete curbing and paved parking lot expansion. Where only 10 automobiles could formerly be parked, provision has now been made for 32 parking spaces. A lower parking concourse traverses the entire 187 feet of site width at the rear of the building.

The project architect, W. R. Henry, A.I.A., of Jackson, said that the contract called for complete interior and exterior painting as a final step. The interior of the existing building was due for painting last year, but the work was deferred so that the all-fresh interior might be part of the addition completion.

The building committee and architect estimate that occupancy of the new addition by the association's executive staff will begin by Jan. 1.





Completed structural steel, left, in the association's building addition shows cantilever design with column-free interior. Steel rises above substructure which houses lower level. Right, interior and exterior masonry walls go up rapidly, with metal door frames standing by for installation. Cavity between masonry layers is fully insulated.

Nine State M.D.'s Are ACS Fellows

Nine Mississippi physicians were among the estimated 1,523 surgeons who were recently inducted as new Fellows (members) of the American College of Surgeons in cap-and-gown ceremonies at San Francisco.

The Mississippi initiates were: Drs. Richard S. Hollis of Amory, Charles E. Farmer, Jr. of Columbus, John C. Sandefur of Greenville, Richard A. Johnson of Hattiesburg, William L. Weems and Richard L. Yelverton of Jackson, Edsel F. Stewart of McComb, Frank H. Tucker, Jr. of Meridian, and Benton M. Hilbun of Tupelo.

Fellowship, a degree entitling the recipient to the designation "F.A.C.S." following the doctor's name, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one or another of the branches of surgery, and who give evidence of good moral character and ethical practice.

The 1969 induction was the largest in the history of the College, founded in 1913.

The American College of Surgeons is a voluntary scientific and educational association of surgeons, numbering 30,000 in 92 countries. The College was organized to improve care of the surgical patient, and has pioneered in many directions in making surgical care as excellent as it is today.

IRS Will Supply Missing Returns

Victims of Hurricane Camille who lost personal records and who will need copies of tax returns are urged to request copies as soon as possible.

J. G. Martin, Jr., District Director of Internal Revenue, states the Internal Revenue Service expects to receive many requests for copies of prior year income tax returns from taxpayers who lost most or all of their records in Hurricane Camille. Copies of returns may be needed for purposes of securing loans as well as for preparation of current returns.

Procedures have been established for expeditious processing of such requests, Mr. Martin announced, and every effort will be made to furnish the material requested as soon as possible. The Internal Revenue Service is required to make a nominal charge to cover reproduction costs.

Requests may be made by telephone to the Gulfport office or by letter to the office of the District Director, P. O. Box 370, Jackson, Mississippi 39205.

Scientific Exhibits Are Invited for 70 Meet

An invitation to scientific exhibitors to apply for space at the 102nd Annual Session, May 11-14, 1970, at Biloxi has been issued in behalf of the Council on Scientific Assembly by Dr. Walter H. Simmons of Jackson, chairman.

Dr. Simmons said that the invitation is open to members of the association, medical institutions, and scientific foundations and similar organizations.

Application for exhibit space and listing in the annual session program should be made to the association at the Jackson headquarters, Dr. Simmons said. No forms are necessary, a letter being sufficient.

The application should state the title of the exhibit, the name or names of authors, and the minimum amount of linear wall space required, Dr. Simmons added.

"We were crowded in the scientific exhibit hall at the 1969 meeting," Dr. Simmons noted. "While we were delighted to have such excellent exhibits, some authors over-estimated their space requirements, asking for more than was necessary."

The chairman emphasized that minimum space requirements be requested, so that no worthy exhibit would be omitted from the presentation by reason of lack of space.

Exhibitors are also asked to specify any special requirements such as high voltage service, tables, and other equipment which might have to be procured.

The association's Scientific Achievement Award will be presented to the best nonmember exhibitor or out-of-state showing. A cash purse honorarium will be presented to the member whose exhibit is judged best, Dr. Simmons said.

In 1969, this honorarium was $500, won by Drs. Albert L. Meena and Henry B. Tyler of Jackson for their exhibit, "Intravenous Demand Permanent Pacemakers in Community Hospitals."

Dr. Simmons said that the deadline for scientific exhibit applications is Feb. 1, 1970, if the exhibitor desires to be listed in the program. Exhibits are selected by a committee of the Council on Scientific Assembly on a first-come, first-served basis.

Coast Physicians Hold Athletic Seminar

Physicians on the Gulf Coast, under the auspices of the American College of Surgeons, held an athletic injury seminar for coaches in late summer at Memorial Hospital at Gulfport.

About 60 coaches from coastal area high schools attended the meeting. Mr. Joe L. Worden, trainer for the Vanderbilt football team for the past 20 years under four different coaches, gave the principal address. He illustrated taking the injured player off the field, strapping ankles and knees and held a question and answer period.

Dr. Kendall Gregory of Gulfport talked on heat exhaustion, drawing from his army experiences of training troops for desert fighting.

Dr. Durant Dabbs of Gulfport spoke on the heart condition, pertaining to athletes. He gave the cause for sudden death from heart trouble, and emphasized that a simple heart murmur should not be a criteria for not being an athlete, but should only be a criteria for being surveyed. Dr. Dabbs also illustrated cardiac massage and artificial respiration.

Dr. George Hancock discussed when the injured player should return to the game. Dr. A. C. Hewes of Gulfport was program chairman, and Dr. Jerry R. Adkins of Biloxi was moderator of the question and answer period.

MACLD Schedules Annual Conference

The Mississippi Association for Children with Learning Disabilities will hold its annual conference in Natchez at the Eola Hotel on Jan. 30 and 31, 1970.

The theme of this year's conference will be "The Key to Their Future," and the planned program of events will include distinguished specialists in the field of medicine and education.

MACLD is a branch of the International Association for Children with Learning Disabilities, which has been in existence since 1962. The Mississippi Organization was chartered in March, 1969.

Among those who will appear as guest speakers at the conference are Edward Frierson, Ph.D., Educational Programs and Resources, Inc., Nashville, Tennessee, and lecturer at the University of Tennessee, Nashville Center, and Lucius Waites, M.D., Director of the Texas Scottish Rite Hospital for Crippled Children, Dallas, Texas. A possible guest speaker will be Dr. Lewis Williams, psychiatrist from Beaumont, Texas. Dr. Williams specializes in treating children with emotional disorders related to learning disabilities and will speak on this subject.

Dr. Frierson will give an overview of learning disabilities in education. Dr. Frierson has a comprehensive knowledge of the various programs conducted in the field of special education and is an eminent authority in the field of learning disorders.

Dr. Waites will talk on specific dyslexia and related language disabilities.

MRMP Sponsors Pulmonary Seminar



Dr. Watts Webb, left, thoracic and cardiovascular surgery chief at Southwestern Medical School at Dallas, and Dr. Guy D. Campbell, Mississippi Regional Medical Program coordinator, discuss the pulmonary seminar presented at the University Medical Center in October. The course, which included lectures and sandwich seminars, featured guest speaker Dr. Webb, former professor of surgery at the School of Medicine, and 16 Medical Center faculty and staff. The University School of Medicine Postgraduate Education Committee cooperated and the Mississippi Regional Medical Program presented the seminar.

SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; the asterisk (*) indicates an original article in the JOURNAL, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M" respectively.

Matter pertaining to MSMA is indexed under "Mississippi State Medical Association." For the author index see page 577.

A

Abortion
moral problem, seminar on, 77-N
reform of state statutes [Kennedy] 103-E
therapeutic, changing views [Kennedy] 425-E
Accidents
auto—better emergency care sought for highway victims, 435-N; Ohio driver convicted of vehicular homicide in death of seven-months viable fetus [Kennedy] 513-E
Action on Smoking and Health
objectives and accomplishments [Kennedy] 99-E
Adenocarcinoma
of endometrium, therapeutic considerations [Boronow] *451
Alabama Medical College
opens telephone information service for state physicians, 492-N
Alabama Regional Medical Program
operates telephone information service at medical college, 492-N
Alcohol
alcoholism and pastoral care, subject of 9th annual Institute for Pastoral Care, 232-N
education, NIH research grant renewed at Mississippi State University, 532-N
progress in care for alcoholics [Kennedy] 474-E
Allergy: See American Academy of Allergy
American Academy of Allergy
schedules postgraduate course, 531-N
American Academy of General Practice
cancer survey tests one million women, 224-N
exhibit at annual meeting brings new hope for multiple sclerosis patients, 530-N
Lotterhos, W. E., is president-elect, 525-N
to help organize residencies, 228-N
American Academy of Pediatrics
announces program for child health personnel, 450-N
guidelines published for competitive athletics for children, 374-N
issues policy on malnutrition, 118-N
says substandard housing major factor in childhood lead poisoning, 532-N
American Association of Blood Banks
1969 annual meeting, 530-N
American Association of Medical Assistants
gives certification test to 288 examinees, 450-N
presents membership award to Mississippi organization, 34-N
American Board of Family Practice
sets first examination, 520-N
American College of Physicians
regional meeting—set for New Orleans, 35-N; 12 Mississippi physicians appear on program, 280-N
sets regional scientific meeting for Point Clear, Ala., 444-N
slates meeting for USAF internists, 68-N
American College of Radiology
separate billing studies [Kennedy] 426-E
American College of Surgeons
approved cancer registry programs —latest official listing [Kennedy] 261-E; Howard Memorial Hospital omitted [Plauche] 363-L
committee on trauma, educational program on better care for highway victims, 435-N
names new director, 228-N
nine state physicians inducted as fellows, 567-N
sets three sectional meetings, 72-N
American EEG Society
schedules course, 77-N
American Heart Association
arrhythmias testing unit available, 224-N
three new heart monographs published, 116-N
American Hospital Association
reports rise in hospital costs, 218-N
American Medical Association
Advisory Board for Medical Specialties and the Council on Medical Education approve specialty board in family practice, 180-N
Board of Trustees revises investment policies to avoid any conflict of interest [Kennedy] 361-E
Committee on Medical Aspects of Automotive Safety, meeting to develop a standardized tissue damage scale for use in crash injury research studies, 379-N
Committee on the Medical Aspects of Sports, guidelines published for competitive athletics for children, 374-N
"Community Health Week," 449-N
Council on Foods and Nutrition, co-sponsors programs on nutrition, 483-N
Education and Research Foundation, the cause is medical education [Kennedy] 470-E
legislative program takes initiative, 368-N
National Conference on Physicians and Schools, 443-N
president-elect urges insurance improvements, 34-N
Speakers' Program receives award, 279-N
spokesmen comment on Medicaid physician regulations [Kennedy] 475-E
Anderson, William Joseph
receives honor at Vanderbilt graduation, 374-N
Athletics
competitive, for children, guidelines published, 374-N
Automobile: See also AMA Committee on Medical Aspects of Automotive Safety
accidents—better care sought for highway victims, 435-N; Ohio driver convicted of vehicular homicide in death of seven-months viable fetus [Kennedy] 513-E

B

Bell, Oliver E.
gets Multiple Sclerosis Society grant, 120-N
Benoist, Edwin E.
named to Fifty Year Club, 262
Berman, Maxwell D.
named physician of the year by Central Mississippi Chapter, Mississippi Association of Medical Assistants, 35-N
Birmingham Academy of Medicine
sets 12th annual Medical Progress Assembly, 378-N
Blindness: See National Society for the Prevention of Blindness, 117-N
Blood: See also American Association of Blood Banks
assurance plans, an answer to blood shortages [Hartney] *244
Book Reviews and Books Received
Adriani, John: Appraisal of Current Concepts in Anesthesiology, Vol. IV [Marland] 365
Anderson, W. A. D., and Scotti, Thomas M.: Synopsis of Pathology, Ed. 7 [Heard] 517
Baronofsky, I. D.: Atlas of Precautionary Measures in General Surgery [Field] 563
Cowdry, E. V.: The Care of the Geriatric Patient [Mitchell] 517
DeWeese, David D.: Textbook of Otolaryngology [Arnold] 437
Fishbein, Morris: Morris Fishbein, M.D., An Autobiography [Kennedy] 366
Georgiade, N. G.: Plastic and Maxillofacial Trauma Symposium, 518
Goldman, Douglas, and Ulett, George A.: Practical Psychiatry for the Internist [McGee] 487

Hartstein, Jack: Questions and Answers on Contact Lens Practice [White] 487
Nelson, Waldo E., *et al.*: Textbook of Pediatrics, 518
Nose, Yukihiko: Manual on Artificial Organs, Vol. I, The Artificial Kidney, 518
Shirkey, Harry C.: Pediatric Therapy, Ed. 3 [Stokes] 365
Slaughter, Frank: Surgeon's Choice, 518
Smallpiece, Victoria: Urinary Tract Infection in Childhood and Its Relevance to Disease in Adult Life, 518
Twenty-Second Annual Symposium on Fundamental Cancer Research: Exploitable Molecular Mechanisms and Neoplasia [Gillespie] 437
Ulett, George, and Goodrich, D. Wells: A Synopsis of Contemporary Psychiatry, 518
Varga, Charles: Handbook of Pediatric Medical Emergencies, Ed. 4 [Nichols] 563
Boone, H. L.
sustained in professional liability suit, 119-N
Bristol Laboratories
studies Chinese herb medicines [Kennedy] 513-E
Brucellosis
Mississippi designated modified certified area, 114-N
Brumby, Paul B.
elected MSMA president-elect, 265-N
Butler, Frank L., Jr.
named to JMSMA post, 520-N

C

Campbell, Guy D.
physician advisor to Mississippi Association of Medical Assistants, 449-N
Cancer: See Neoplasms
Carcinoma
bronchogenic, changing concepts of management with irradiation [Hickman & Parker] *125
of the esophagus [Netterville] *503
primary, of lung, prevention, diagnosis and treatment [Bowlin] *331
Carlson, David I.
sustained in professional liability suit, 119-N
Cerebral Dysfunction
clues to neurological disorders in children [Jabbour] *8
Cerebrovascular Disorders
stroke, UMC care demonstration unit, report on first 100 cases [Haerer *et al.*] *237
Chamber of Commerce of the United States
revises policy on Medicare [Kennedy] 361-E
Children
cerebral dysfunction, clues to neurological disorders [Jabbour] *8
competitive athletics, guidelines published, 374-N
vomiting, control of, a clinical comparison of rectal pyrilamine maleate and trimethobenzamide hydrochloride [Tibbs] *130
Clinicopathological Conferences
XCIII [Wilson—Mississippi Baptist Hospital] 43
XCIV [Wilson—Mississippi Baptist Hospital] 249
XCV [Wilson—Mississippi Baptist Hospital] 545
Cohen, Wilbur J.
not retiring—just moving [Kennedy] 21-E
College of American Pathologists
USA v. CAP, consent decree reached [Kennedy] 357-E
Coma
diagnosis of peritonitis in unconscious patient [Timmis] *1
Conway, John W., III
convicted of fraud under Medicare, 481-N
Coronary Disease
drug research study, 27-N

D

Deaths
Adams, John Charles, 562
Aiken, James Wilson, 516
Anderson, William H., 321
Bane, John Roy, Jr., 562
Barrett, Irwin William, 174
Biggart, James Flimen, 434
Blackwelder, Bron-Dee, 262
Box, William Edgar, 174
Cashman, George A., 363
Charlton, Alton F., 321
Chisolm, James Julian, 174
Coe, James Eddy, 363
Crumby, Homer Floyd, 262
Frazier, Thomas W., 321
Gilbert, Edward Lee, 434
Grimm, Jay John, 26
Harris, William Robin, 26
Haslitt, Percy P., 321
Herrington, Joseph Clarence, 262
Howard, Homer Lamar, Sr., 262
Knox, Isaac Cecil, Sr., 479
Leigh, Robert Matthews, 363
McBryde, William Walker, 174
McCann, Ezelle, 562
McMillan, Amon Kennedy, 217
Moore, Daniel H., Sr., 26
Oates, Junius Kennedy, 434
O'Mara, B. B., 321
Parsons, Willard Herring, 217
Puryear, Harry Henton, 218
Rembert, George William Frances, 60
Russell, John Charles, Jr., 110
Sappington, Millard Cartwright, 479
Warren, George Torrey, 363
Wilkins, E. Leroy, 26
Wingo, Maurice Ross, 562
Dermatitis
caused by flea collars, 77-N
Dermatology
history, Syntex publishes fourth volume, 70-N
Disaster
care, Copiah, Smith and Scott County tornado, an assessment [Martin] *96
Hurricane Camille—air guard commander honored for evacuation work, 524-N; Meridian physicians care for nursing home patients [Kennedy] 557-E; milk industry praised for help, 528-N
Dow Corning Corporation
Medical Products Division announces implant prosthesis, 120-N
Drug Industry
Bristol Laboratories studies Chinese herb medicines [Kennedy] 513-E
companies send supplies for hurricane victims, 488-N
Smith Kline & French Laboratories—to code packages, products, 218-N; to end medical color television unit programs [Kennedy] 100-E
Syntex publishes fourth dermatology history, 70-N
Drugs
bibliography of biopharmaceutics published, 71-N
Chinese herb remedies, Bristol Laboratories studying [Kennedy] 513-E
coronary, UMC and VA join in research study, 27-N
Depo-Medrol brings remission in multiple sclerosis, 530-N
dextran, low molecular weight, clinical experience in acute myocardial infarction [Langsjoen] *499
Robaxin, case report of convulsion following IV administration [Meek] 518
Mississippi Jaycees collect drug samples for Asian hospitals, 522-N
prescription, substitution, old problem with new faces [Kennedy] 313-E
rectal pyrilamine maleate and trimethobenzamide hydrochloride for vomiting in children [Tibbs] *130
research, PMA underwrites new studies, 32-N

E

East Mississippi State Hospital
workers sue for wage minimums, 118-N
Education, Medical
Emory University increases student electives, 33-N
from Flexner to Millis, six decades of miracles [Kennedy] 257-E
postgraduate calendar, 23, 58, 104, 168, 215, 362, 429, 475, 513, 560
what AMA-ERF is all about [Kennedy] 470-E
Ellis, E. E.
sustained in professional liability suit, 119-N
Emory School of Medicine
students to have increased electives, 33-N
Endometrium
cancer, therapeutic considerations [Boronow] *451
Erythema Multiforme
complicating smallpox vaccination [Scott & Pankey] *41
Esophagus
carcinoma, a case report [Netterville] *503
Exobiology
moon bugs, no laughing matter [Kennedy] 425-E

F

Family Planning
Mississippi State Board of Health project, 443-N
the Tydings bill, a vehicle for discussion [Kennedy] 362-E
Fetus
Ohio driver convicted of vehicular homicide in death of seven months viable fetus [Kennedy] 513-E
Foods
non-nutritive sweeteners, are they safe? [Kennedy] 213-E
Fox, J. H.
turns over written recollection of Vicksburg Medical School to State Board of Health Library, 219-N

G

General Practice: See also American Academy of General Practice, American Board of Family Practice
specialty board approved, 180-N
Glaucoma
therapy simplified [Knopf] *457
Gray, Archie L.
portrait unveiled at State Board of Health, 67-N
Grenfell, Raymond F.
new SMA counselor, 33-N

H

Hamrick, D. W.
is new State Board of Health president, 483-N
Handicapped
"National Employ the Physically Handicapped Week" set, 436-N
Hardy, James D.
receives double honors, 231-N
Health Care
delivery system—on trial [Kennedy] 421-E; president of Blue Cross Association proposes slashing reforms [Kennedy] 211-E; remade in whose image? [Kennedy] 509-E
manpower shortage, womanpower may be the answer [Kennedy] 314-E
Hearing
blast of rock and roll groups can cause loss [Kennedy] 212-E
Heart: See also American Heart Association
arrythmias, experiences with electrical cardioversion in outpatient clinic [Woodbridge] *542
cardiac surgery in infants [Timmis *et al.*] *283
coronary drug research, UMC, VA join nationwide project, 27-N
transplant, UMC team performs, 70-N
Heart Block
complete right bundle branch block in right ventricular overload [Hutchinson] *88
permanent cardiac pacing [Timmis *et al.*] *83
Hinds County Kidney Disease Foundation
supports UMC home dialysis training program, 76-N
Holmes, Verner S.
unhurt in aircraft mishap, 231-N
Hospitals: See also American Hospital Association
charges, effect of second round of minimum wage increases on [Kennedy] 20-E
costs, the tight dilemma [Kennedy] 317-E
East Mississippi State Hospital, workers sue for wage minimums, 118-N
Memphis, ask greater compensation for Mississippi indigent patients [Kennedy] 19-E
visitation practices, 368-N
Hyman, O. W.
noted Tennessee medical educator dies, 63-N

I

Infants
cardiac surgery [Timmis *et al.*] *283
Infants, Newborn
with respiratory disease syndrome, transport system [Arp *et al.*] *412
Insurance, Health
Blue Cross-Blue Shield—Blue Cross Association president proposes slashing reforms of health care system [Kennedy] 211-E; Board of Directors of National Association pledges cooperation for Medicare improvement, 79-N; Mississippi plan (installs usual, customary and reasonable fee program for federal employees) 28D-N, (realigns top management) 529-N
mountain of paper work [Kennedy] 102-E
test for your policy [Kennedy] 22-E
voluntary—AMA president-elect urges improvements, 34-N; Individual Responsibility Program [Rogers] *298
Insurance Institute for Highway Safety
finances program for better care for highway victims, 435-N
Insurance, Liability
MSMA program produces lower professional rates [Kennedy] 512-E
professional premium rates hit new highs, 61-N
the growing crisis in professional insurance [Kennedy] 53-E
Insurance, Life
industry fights slums and depression of inner city [Kennedy] 360-E
International College of Surgeons
offers award for best surgery paper, 479-N
Intestine
small, importance of technique in roentgen examination [Nice] *201

J

Joint Commission on Accreditation of Hospitals
new officers and members, 110-N
Joint Council of National Pediatric Societies
urges Head Start continuation and extension, 230-N
Jurisprudence
conviction of vehicular homicide in death of seven-months viable fetus, landmark case [Kennedy] 513-E
major precedent set in administration of public medical care programs by private organizations under contract to government [Kennedy] 213-E
Laurel physicians sustained in professional liability suit, 119-N
USA v. CAP, consent decree reached [Kennedy] 357-E

K

Kennedy, Rowland
denies "Moonshine charge," 523-N

L

Legislation
91st Congress to be less enthusiastic than predecessor over another Medicare [Kennedy] 55-E
Tydings Bill on family planning [Kennedy] 362-E
Letters
case report of convulsion following IV administration of Robaxin (Meek) 518
Howard Memorial Hospital omitted from ACS listing of approved tumor registries [Plauche] 363
thanks to Mississippi medicine [Gore] 318
Life Expectancy
U.S. Senate is no place to grow old [Kennedy] 469-E
Life Insurance Medical Research Fund
gives $1.4 million in grants and fellowships, 76-N
Lilly, Eli, and Company
reports on cancer research, 225-N
Liver
scanning [Flowers] *401
Long, Lawrence W.
attends biennial conference of state journal leaders, 530-N
Lotterhos, William E.
named AAGP president-elect, 525-N
Lungs
left pulmonary aplasia [Coffey & Watson] *37
primary carcinoma, prevention, diagnosis and treatment [Bowlin] *331

M

McWilliams, George M.
MSMA board honors, 524-N
Mallon, Mary
forgotten figure of history [Kennedy] 21-E
Malnutrition
American Academy of Pediatrics issues policy, 118-N
no subject for political capital [Kennedy] 54-E
Masonite Corporation
gives $1.5 million medical facility to Jones County, 177-N

Mathews, Charles L.
resigns MSMA executive post, 220-N
Measles
epidemic in Dominican Republic, 78-N
Hattiesburg, McComb, and Natchez sponsor immunization campaigns, 35-N
vaccine, tests scheduled, 446-N
Measles, German
vaccination program planned, 525-N
Medical History
dermatology, Syntex publishes fourth volume in series, 70-N
in Marion County, memorial book begun, 374-N
Mary Mallon, forgotten figure of history [Kennedy] 21-E
records of Vicksburg Medical School turned over to state board of health library, 219-N
Medical Organization: See also specific titles such as American Medical Association, Mississippi State Medical Association
state and national meeting schedules, 17, 82, 121, 176, 209, 399, 534,
Medical Practice
group practice, pattern of the future? [Kennedy] 165-E
in Marion County, memorial book begun, 374-N
medicine under attack, crazy contradictions [Kennedy] 167-E
Medical Science
astonishing accomplishments in 169 years [Kennedy] 55-E
Chinese herb medicine, what can today's practitioners learn from it? [Kennedy] 513-E
medicine of the 1970s [Kennedy] 103-E
Members, New
Abney, Robert Luther, III, 106
Armstrong, William Riddick, 106
Ballard, James Lee, Jr., 172
Barta, Lloyd Leslie, 107
Bland, Anna Nell, 172
Blount, Richard Lamar, 362
Blount, Robert Estes, 107
Boronow, Richard Carlton, 518
Bradford, William Meredith, 56, 216
Burrow, Nancy Watts, 263
Campbell, Jonathan Cross, 216
Carruth, Edward Leston, 216
Collins, Kenneth, 564
Colson, Richard Lorence, 107
Cook, Donald Eugene, 172
Cottrell, Hugh Barnette, 107
Day, James Randolph, 107
Depoyster, James Harold, 216
Deraps, Gordon Douglas, 58, 216
Donald, Robert Lavalle, 216
Doster, James Thomas, 58, 216
Edwards, Charles Mims, 107
Elliott, Wayne Gordon, 216
Evans, John Ellis, 434
Flechas, Enrique, 216
Gates, William Carey, Jr., 216
Gordon, James Don, 216
Gordon, James Otis, Jr., 172
Hancock, George Marvin, 216
Henderson, Julian Crowder, 174
Hilbun, Glyn Roy, 216
Hubbert, Charles Hughes, 107
Jackson, John Rushing, Jr., 362
Joffe, Irwin, 217
Johnson, Sol Escol, Jr., 217
Kirk, Andy Ellzey, 58, 217
Ladner, George Dale, 58, 217
Lampton, Theodore Dudley, 363
Long, William Alexander, Jr., 217
Lott, Robert Townsend, 217
Love, Robert Taylor, 564
McAfee, James Earl, 564
McKell, William McArn, Jr., 217
Maier, Alice Hull, 263
Maier, Findlay George, 263
Marascalco, Charles Anthony, 217
Munn, William George, 107
Nealy, Wrendell Ré, 321
Nettles, Dexter Conley, 107
Overby, James Allen, 263
Owens, William Franklin, Jr., 564
Patino, Carlos Saul, 174
Patrick, Bernard Sutherland, 479
Purvis, Thomas Leo, Jr., 263
Rogers, Lee Hartwell, 479
Ross, Joe Monroe, Jr., 321
Russell, Jerry Ted, 107
Sanders, James William, 107
Schmidt, Robert J., 174
Sherline, Donald Morton, 363
Sinclair-Hall, Alvah H., 263
Steckler, David Robert, 564
Stith, James Logan, 217
Sykes, Henry Harvey, Jr., 263
Taylor, Eugene Edward, 107
Taleff, Michael, 564
Trunzler, Basil Guice, 107
Waller, Thomas Eustace, 58, 217
Wansley, Billy Morris, 174
Young, John Randolph, Jr., 107
Meningitis
tuberculous, a study of general hospital patients in Mississippi [Ricks & Allison] *196
Mississippi Advisory Health Planning Council for the Comprehensive Health Planning Program
governor names eight M.D.'s as members, 447-N
Mississippi Appalachia Health Advisory Committee
three M.D.'s nominated for MSMA representative post, 77-N
Mississippi Association for Children with Learning Disabilities
1970 annual conference, 568-N
Mississippi Association of Medical Assistants
Central Chapter—names Dr. Maxwell D. Berman "Physician of the Year," 35-N; new officers elected, 78-N; Mrs. Polly Shotwell awarded first honorary membership, 174-N
Delta Chapter, names medical advisers, 279-N
Dr. Guy D. Campbell named physician advisor, 449-N
sponsors courses at UMC, 578-N
wins national membership award 34-N
Mississippi Baptist Hospital
names staff officers, trustees, 190-N
Mississippi Federal-State Program Office
receives $50,000 Appalachian award, 375-N
Mississippi Heart Association
announces 1969-70 grants, fellowships program, 74-N
Mississippi Hospital Association
sets 38th annual convention, 329-N
Mississippi Jaycees
collect drug samples for Asian hospitals, 522-N
name scholarship recipients, 528-N
Mississippi Postgraduate Institute in the Medical Sciences
to register first class, 438-N
two courses completed, 521-N
Mississippi Psychiatric Association
fall meeting, 522-N
Mississippi Public Health Association
new offices, 578-N
Mississippi Regional Medical Program
cancer conferences set weekly at UMC, 519-N
courses for medical assistants, 578-N
funds Mississippi Postgraduate Institute, 438-N, 521-N
pulmonary seminar, 568-N
stroke unit program—first refresher course on stroke and related neurological diseases at UMC, 63-N; review of first 100 cases [Haerer *et al.*]* 237
Mississippi State Board of Health
board—first, Dr. James Marcus Taylor, member [Price] *417; nine MSMA members nominated for three positions, 325-N; president is Dr. D. W. Hamrick, 483-N
Delta Pilot Project—purposes and achievements [Rausa] *406; funded program needs health officers, 449-N
family planning project, 443-N
library, receives rare historical records of Vicksburg Medical School, 219-N
medical students get first hand training in local clinics, 448-N
portrait of late Dr. Archie L. Gray unveiled, 67-N
praises state milk industry, 528-N
Preventable Disease Control Division, German measles vaccination program, 525-N
screening program for first graders, 367-N
Tate County Health Department, is dedicated, 488-N
TB prevention program reviewed, 66-N
waste disposal research—garbage disposal studied, 78-N; federal funds requested for preparation of statewide disposal program, 119-N; statewide survey of solid-waste problem, 223-N
Mississippi State Hospital Commission
payments to Memphis hospitals for state indigent patients [Kennedy] 19-E
Mississippi State Medical Association
Amite-Wilkinson County Medical Society, names new officers, 77-N
advisory committee for Comprehensive Health Planning task force, 28-N

associate executive secretary resigns post, 220-N
board of trustees—honors air guard commander, 524-N; new officers, 277-N; program to lower professional liability premiums [Kennedy] 512-E
Central Society, hears program on blood assurance plans, 232-N
Coast Counties Medical Society, 1969 officers, 33-N
Committee on Publications—chairman attends journal conference, 530-N; Frank L. Butler, Jr., succeeds B. B. O'Mara, 520-N
co-sponsors programs on nutrition, 483-N
Constitution and By-Laws, 302
Emergency Medical Care Unit, opens for special Medicaid session, 441-N
executive denies "moonshine charge," 523-N
Fifty Year Club, new members—Benoist, Edwin E., 262; Sheffield, G. T., 33-N
group life insurance program to offer new bonus, 434-N
headquarters addition—ground broken, 323-N; continues on schedule, 372-N; foundation completed, 440-N; to be occupied by January, 1970, 482-N; substructure completed, 523-N; interior trimming underway, 566-N
helps seek physician for Parchman, 62-N
Homochitto Valley Society, changes name to Adams County Medical Society, elects officers, 72-N
House of Delegates—handbook of 101st annual session, 161; news report on proceedings, 269-N; text of proceedings, 341-N
Journal—advertising sales chief wins honor [Kennedy] 317-E; is 10 years old [Kennedy] *559
nominates three M.D.'s for MSMA post on Mississippi Appalachia Health Advisory Committee, 77-N
nominates nine M.D.'s for State Board of Health positions, 325-N
nominating committee meets, 66-N
officers, trustees and councils listing, 80, 122, 234
101st Annual Session—new officers named, 265-N; news report, 265-N; official call and program, 133; scientific exhibits invited, 28D-N
102nd Annual Session—scientific assembly begins work, 277-N; scientific exhibits are invited, 567-N
partner with UMC in Mississippi Postgraduate Institute in the Medical Sciences, 438-N, 521-N
Prairie Medical Society, names new officers, 74-N
president urges study of Medicaid, 329-N
President's Page, Rogers—"Positive with Prevention," 18; "A Two-Way Street," 52; "The Voice of Medicine," 98; "Must We Be Last?", 164-N; "Carrying the Tasks Forward," 210
President's page, Royals—"Wanted," 256; "Politics: Not a Dirty Word," 312; "Warranty of Integrity," 356; "A Matter of Equity," 420; "The Call Was Answered," 468; "Basis of Excellence," 508; "Supply and Demand," 554
Robins Award, Omar Simmons is recipient, 278-N
Rogers, Joseph B., is new AMA alternate delegate, 277-N
Singing River Medical Society—chartered, 33-N; elects officers, 28-N
Mississippi State Sanatorium
states compliance policy, 489-N
Mississippi State University
ambulance driver course, 434-N
NIH renews alcohol education grant, 532-N
Mississippi Thoracic Society
13th annual Tri-State Consecutive Case Conference, 117-N
Mississippi Tuberculosis and Respiratory Disease Association
launches "Quit Smoking" effort, 368-N
Mississippi Tuberculosis Association
13th annual Tri-State Thoracic Society Consecutive Case Conference, 117-N
Mitchell, C. B.
pre-med fund at MSU, Dr. Alton Ochsner is first speaker, 115-N
Mound Park Hospital Foundation
third hospital postgraduate conference, 445-N
Multiple Sclerosis: See also National Multiple Sclerosis Society
Depo-Medrol brings remission, 530-N
Myocardial Infarction
clinical experience with low molecular weight dextran [Langsjoen] *499

N

National Aeronautics and Space Administration
offers book on bioinstrumentation, 190-N
National Multiple Sclerosis Society
awards $31,755 research grant to UMC researcher, 120-N
National Society for the Prevention of Blindness
offers funds for pilot research projects, 117-N
Neoplasms
cancer in nuns, NIH studies, 232-N
cancer of cervix, AAGP-PHS survey, 224-N
cancer research, Eli Lilly reports two developments, 225-N
cancerous cells appear not to produce substance which shuts off protein in crowded masses of normal cells, 222-N
NIH publishes booklet on "Virus-Cancer Research," 230-N
tumor registries—latest ACS listing [Kennedy] 261-E; Howard Memorial Hospital omitted from ACS listing [Plauche] 363-L
Neurological Disorders
in children, clues in cerebral dysfunction [Jabbour] *8
North Carolina Committee on Patient Care
study of visitation practices, 368-N
Nutrition
MSMA & AMA sponsor lectures, 438-N

O

Ochsner, Alton
talk is sponsored by the C. B. Mitchell Pre-Med Fund at MSU, 115-N

P

Pancreas
Zollinger Ellison Syndrome, discussion and case report [Kluck & Hardy] *535
Pasteur, Louis
letters published by University of Alabama Press, 533-N
Pathology: See College of American Pathologists
Pediatrics: See American Academy of Pediatrics
Pender, C. A.
portrait given to Montfort Jones Memorial Hospital, 226-N
Peritonitis
diagnosis in unconscious patient [Timmis] *1
Personals
Abernethy, Lynn D., 59
Abney, Robert L., 169, 320
Adkins, Jerry R., 105
Ainsworth, Temple, 320, 516
Akutsu, Tetsuzo, 432
Allen, Clyde R., Jr., 430
Anderson, William, III, 560
Anderson, William H., 169
Andy, Orlando J., 169
Arnold, Godfrey, 364
Arrington, George L., Jr., 430
Atwood, John G., 561
Austin, S. D., 320
Baird, Frank J., 431
Barkley, T. J., 431
Barry, Esther G., 560
Bass, Ross, 478
Beacham, A. V., 24, 215
Becker, Jasper B., Jr., 105
Bell, Warren, 363
Benefield, Tom E., Jr., 515
Benoist, Edwin E., 262
Berman, Maxwell D., 320
Berry, Perrin L., 319
Blake, Thomas M., 59
Blissard, Thomasina, 321
Blount, Richard L., 169
Bobo, Edgar E., 169
Bobo, William P., 59
Bologna, N. A., 215
Bower, John D., 320, 363
Braddock, T. N., 515
Bradford, Bert E., 430
Bramlitt, E. E., 561
Bratley, Forrest, 478
Bridges, William D., 430
Broadus, L. Z., 561
Brock, D. T., Jr., 106
Brock, Ralph, 561
Brown, A. E., 431, 561
Brumby, Paul B., 515
Buckley, Theresa L. R., 262, 364, 561
Burgess, C. Duane, 516
Burman, Richard G., 59
Burrow, Hollis, 478, 561

Busey, John F., 319, 320
Bynum, Gus A., 105, 478
Caine, Curtis W., 319, 431
Calloway, James E., Jr., 24
Campbell, Guy, 320, 364, 478, 516, 561
Campbell, Jon C., 105
Campbell, W. Richard, 320
Carney, P. Temple, 364, 561
Carr, William J., Jr., 320
Carroll, Andrew J., Jr., 24, 169
Carter, Robert E., 24, 321, 364
Carter, Robert F., 169
Cash, Jack Q., 321
Causey, Jack Quin, 105
Causey, William A., 430
Cavett, James, 478
Cleveland, Webster, Jr., 515
Coffey, John D., 561
Cole, Wilfred Q., 24
Collins, Rex W., 431
Conn, Francis R., 432
Conner, O. Weir, III, 262
Cook, Gaines L., 262
Cook, Wendell H., 560
Cottrell, Hugh B., 24, 320, 516
Covington, Joe, 560
Cox, Charles J., 24
Crawford, Ben, 478
Crawford, Everett, 478
Crawford, Walter W., 169, 478, 561
Crouch, Lewis, 478
Crowe, D. F., 515
Crowson, W. N., 320
Curry, Max A., 106
Daniel, C. Ralph, 59
Davis, J. T., 321
Davis, Malcolm W., 105
Davis, Woody Dean, 478
Day, L. H., 432
Dodson, Marion L., 24, 515
Dominick, Thomas, 478
Downer, John G., 516
Dudley, W. H., Jr., 364
Durfey, A. P., 516
Durfey, Allan Percy, Jr., 516
Durfey, John R., 516
Eckford, J. F., 516
Ederington, John B., 431
Edwards, C. Mims, 24, 59
Elliot, John R., Jr., 105
Ellis, David, 431
Ervin, Robert N., 105
Estess, John M., 169
Evans, Ben P., 516
Evans, John E., 59, 478
Fabian, Leonard W., 364
Farber, Louis A., 24, 105
Farmer, Charles E., 516
Field, R. J., Jr., 106
Flagg, Geddes B., 478, 516
Flanagan, Patrick M., 432
Flowers, Richard, 516
Flynn, A. G., 516
Ford, John M., 364
Foster, J. Ray, 106
Fridge, Harry, 320
Frye, Harry C., 24
Fulcher, Harry, Jr., 431
Furr, Richard T., 24
Gabbert, Elmo, 432
Gandy, Thomas H., 561
Gifford, William B., 478
Gilbert, Wendell N., 431
Giles, William G., 431
Gillespie, Guy T., 478
Gillespie, H. Lamar, 24
Gilliland, R. N., 432
Glasgow, Joseph, 215
Godfrey, Douglas, 431
Goodloe, William H., Jr., 431
Goodman, Rexel, 516
Gorton, Mack, 431
Graham, James C., 431
Green, Earl W., 24, 364
Green, John E., 364
Grenfell, Raymond F., 59
Griffith, J. M., 431
Gruich, Frank G., 106
Guerriero, James P., 320
Gunn, Clyde, Jr., 106
Gwin, John V., 516
Hagaman, Van Dyke, 59
Hale, Carl R., 561
Hammett, L. J., 432
Hamrick, D. W., 364
Hardy, James D., 364, 516
Harrell, Felix J., Jr., 106
Harris, James E., 169, 432
Harrison, D. L., Jr., 478
Hartness, Stanley H., 432
Harvey, Marvin V., 24, 60
Haynes, Douglas B., Jr., 432
Hays, A. V., 106
Head, Charles M., 169, 431
Heath, Bobby J., 561
Henderson, Jesse L., 60
Hendrick, Jim, 478
Hendrix, James H., Jr., 262
Henry, Joseph R., 561
Herring, Emmett M., 364
Herring, Jack L., 24
Hiatt, Warren A., 24
Hickman, Bernard T., 364
Hicks, G. Swink, 320
Hinman, M. E., 561
Holleman, J. H., 431
Hollis, Allen U., 169
Holmes, Verner, 319, 516, 561
Hoover, Jack C., 432
Horn, Paul C., 478
House, J. R., Jr., 515
Howell, T. R., 651
Huddleston, W. J., 516
Hudgins, James J., 430
Hull, Calvin, 561
Hunt, William B., 561
Hutchinson, Richard G., 215
Janes, Julian T., 215, 561
Jaquith, W. L., 60
Jenkins, Cecil G., 106
Joffe, Ervin, 106
Johnson, Ben B., 215, 364
Johnson, Samuel B., 24, 59, 262, 364
Jones, Edley H., 516
Jones, James H., 432
Kellum, Henry J., Jr., 320
Kellum, Herman E., Jr., 60
Kilgore, Thomas, 516
Killelea, Donald E., 169
Kitchings, Ben J., 169
Kobs, Darcy G., Jr., 561
Lampton, T. D., 320
Lane, Dewey H., Jr., 172
Langford, Herbert G., 215, 364, 516
Lehan, Patrick H., 26, 561
Levens, John B., 24, 515
Lewis, Clyde J., Jr., 432
Lindsey, Arthur, 320
Lockwood, William R., 364, 432
Long, Lawrence W., 26, 172
Long, William A., 320
Lotterhos, William E., 516
Love, William D., 26
Lynch, Henry, 364
McAfee, James E., 320
McBroom, Robert, 321
McDonnieal, S. H., Jr., 59, 215
McDougal, L. L., 561
McFarland, Wesley L., 24, 561
McGee, Robert R., 432
McGlamery, Roy C., 60
McKinley, Robert L., Jr., 320
McLain, James, 478
McLain, Patrick G., 60
McLaurin, J. P., Jr., 172, 319
McLeod, Andin C., 432
McLeod, Hugh, 516
McLeod, James N., III, 430
McLeod, John A., 24
McRae, John M., Jr., 432
Magee, Dennis E., 364
Magee, Thomas E., 26
Maggio, Henry A., 561
Magiera, Estelle, 320
Martin, George H., 215
Martin, James B., 364
Martin, Raymond, 478
Martinolich, Andrew K., Jr., 432
Mason, Gilbert R., 516
Massey, Samuel O., 364
Massengill, Frank C., 561
Masterson, Chester, 561
Mauney, Jessie, 320
Mayer, Tom, 561
Middleton, William A., 320
Milam, John, 320
Mink, Paul, 432
Mitchell, Charles B., Jr., 172
Mitchell, Shelby W., 432
Moore, Dan H., Jr., 479
Moore, E. Lowry, 479
Moore, Floy J., 478
Moore, W. C., 431
Moran, Carl J., 262, 432
Morphy, A. N., 26, 262
Moynihan, Patricia, 516
Murphy, Eugene, III, 319
Murry, Charles M., 364
Neely, William A., 432
Nelson, Howard, 516
Nichols, Howard H., 60
North, Edward R., 320
Oakes, William T., 320
Ozborn, Charles A., 364
Packer, James M., 106
Parker, William, 561
Pate, S. Ray, 320, 432
Patterson, John M., 320
Patterson, Wilford J., 561
Peacock, Laura, 561
Peede, Robert L., 26, 106, 169, 478, 561
Pickle, Coleman, 432
Pittman, J. J., 478
Plauche, Warren C., 106, 364
Polk, Benjamin P., Jr., 106
Purks, W. K., 172
Purser, Thomas, III, 319
Purvis, George, 478
Puryear, Lamar, Jr., 215
Raines, Oney C., III, 169
Ray, Charles A., III, 432
Rayner, Donald R., 321
Reikes, Dan, 561
Rester, Robert R., 432, 516
Richardson, David D., 215, 320
Riecken, William E., 561

Roberts, Curtis D., 432
Robertson, Roland B., Jr., 215
Robinson, E. E., 560
Robinson, Jo Newell, 60
Robinson, McWillie M., Jr., 105
Robinson, Rudyard B., 26
Rose, Walter H., 26
Ross, Jerry, 320
Ross, T. Erskine, Jr., 24
Ross, T. Erskine, III, 172
Ryan, Everett W., 172
Safley, James E., 215
Samson, Roland F., 169
Scanlon, Leo, 320
Schmidt, Harry J., 106
Schwartz, Robert E., 320
Scoggin, Joe C., 432, 516
Scott, Gray E., Jr., 172
Sekul, Steve, 106
Sharpe, Guy, 516
Shaw, Thomas, 478
Sheffield, Philips A., 106
Shell, John R., 215
Shell, Robert, 561
Sherline, Donald, 364
Simmons, Omar, 432
Sloan, Robert D., 364
Smith, Cleveland B., 478
Smith, Jim, 478
Sneed, Ralph, 172
Spell, Bobby G., 105
Spell, James P., 478, 561
Stanback, C. O., 479
Stauss, Hans K., 26
Stewart, Edsel F., 60
Stith, James L., 262
Stokes, Jack A., 60, 479
Strange, W. W., 515
Stribling, Loutrelle, 106
Strong, David H., 561
Taleff, Michael, 479
Talkington, Thomas W., 432
Taquino, Maurice A., 106
Tatum, Frank K., 320
Tatum, Frederick E., 215
Tatum, Jetson P., 516
Taylor, C. D., Jr., 263, 516
Taylor, Walter T., 432
Terrell, Kenneth D., 320
Thaggard, A. L., 106
Tharp, Charles, 319, 561
Thiede, Henry, 364, 479
Thompson, James Grant, 215
Thompson, R. L., 432
Toms, Roland E., 320, 562
Townes, R. B., 562
Turner, Charles W., 432
Tyler, Myra, 478
Tyson, Robert E., 215
Van Landingham, David J., 60, 106
Vesa, Antonio G., 432
Vick, Walter D., 60
Vickery, George, 478
Waldon, Thomas B., 364
Walker, Elmo L., 364
Walker, Willis, Jr., 432
Ward, R. D., 516
Warriner, R. B., Jr., 562
Watkins, H. C., Jr., 479
White, Elbert A., III, 26, 516, 562
White, Reginald Pace, 562
White, W. B., 561
Whitehead, Thomas B., 320
Whites, Dayton E., 60
Whitfield, E. L., 169
Wiener, Julian, 215
Wilder, S. Jobe, 432
Williams, Charles O., 169
Wilson, David B., 215, 319, 364, 432, 479
Winkler, Marion M., Jr., 319, 561
Wood, J. O., 478, 561
Wofford, Jesse L., 561
Wofford, John, 516
Wyatt, Rhea L., 321, 516

Pfizer Laboratories Division
scholarship awarded Mississippian, 379-N
to give 101 medical scholarships, 231-N

Pharmaceutical Manufacturer's Association
bibliography of biopharmaceutics published, 71-N
foundation offers faculty awards, 531-N
issues prescription drug pamphlet, 190-N
self-training program for packaging employees, 74-N
underwrites new drug research, 32-N

Prosthesis
silastic finger joint prosthesis to help arthritis, trauma victims, 120-N

Psychiatry: See Mississippi Psychiatric Association

Purvis, George D.
named vice-president of the Mississippi Baptist Convention Board, 34-N

R

Radiography
importance of technique in roentgen examination of small intestine [Nice] *201

Radiologic Seminars
Upper Esophageal Webs [Surratt] 6
Abdominal Pregnancy [Hester] 50
Neurotrophic Arthropathy of the Shoulder [McCay] *95
Arthrography of the Knee [Barlow] 207
Intestinal Amebiasis [Burrow] 242
Ascariasis Demonstrated by a GI Series [Smith] *296
Traumatic Myositis Ossificans [Ferguson] 339
Gas in the Biliary System [Williams] 410
Ischial Apophysiolysis [McCay] *466
Radiographic Differentiation Between Renal Cyst and Neoplasm [Gibson] 505
Intracranial Arteriovenous Malformations [Carr] 551

Radiology: See American College of Radiology

Radiometry
hepatic photoscanning, interpretation and limitations [Flowers] *401

Radiotherapy
role in bronchogenic carcinoma [Hickman & Parker] *125

Respiratory System
distress syndrome, in newborns, a transport system [Arp *et al.*] *412

Rhode Island Medical Society
Caleb Fiske Essay subject announced, 370-N

Robins, A. H., & Co.
MSMA award—Omar Simmons receives, 278-N
president gives $50 million to University of Richmond [Kennedy] 426-E

Rogers, Joseph B.
named new AMA alternate delegate, 277-N

Rousseau, Wyatt Easterling
gets M.D. from Vanderbilt, 374-N

Royals, James L.
named president of MSMA, 265-N
urges study of Medicaid, 329-N

S

Sanitation
use of sack service for garbage disposal, 78-N

Scanlon, Leo J., Jr.
is essayist at homicide institute, 190-N

Schools, Medical
and tax support [Kennedy] 168-E

Septicemia
gram-negative, and endotoxin shock [Weems & Aldridge] *191

Sheffield, G. T.
named to Fifty Year Club, 33-N

Shock
endotoxin, rationale of management [Weems & Aldridge] *191

Shotwell, Polly
retires after 46 years as a medical secretary, 174-N

Skin
dermatitis caused by flea collars, 77-N

Simmons, Omar
receives '69 MSMA-Robins Award, 278-N

Smallpox
vaccination, erythema multiforme as complication [Scott & Pankey] *41

Smith, Kline & French
discontinues medical color television unit [Kennedy] 100-E
fellowship goes to UMC junior, 223-N
will code packages, products, 218-N

Snakebites
venomous, fiction versus fact [Parrish] *462

Social Security
act, author (Wilbur J. Cohen) retires as secretary of HEW [Kennedy] 21-E
Medicaid—infrequent abuse must be cleaned up [Kennedy] 261-E; MSMA president urges study, 329-N; regulations on physician limitations [Kennedy] 475-E; the unspeakable alternative [Kennedy] 316-E; the tax challenge [Kennedy] 101-E; Title XIX, day of decision for Mississippi [Kennedy] *291
Medicare—a need to be reasonable about reasonable fees [Kennedy] 555-E; crunch is on Part 1-B expenditures, bill seeks assignments at Shield rates, 113-N; fraud, injurious sensationalism [Kennedy]

471-E; home health agency services, under-utilization [Kennedy] 260-E; major legal precedent set [Kennedy] 213-E; protests mount over fee freeze, 279-N; state physician convicted of fraud, 481-N; U.S. Chamber of Commerce, revises policy on [Kennedy] 361-E
Society of the Plastics Industry
has medical review board to answer physicians' questions, 492-N
Society of Thoracic Surgeons
1970 meeting, 564-N
Southeastern Chapter of the Society of Nuclear Medicine
10th annual meeting, 447-N
Southern Medical Association
lectureship, Weston M. Kelsey, Jr., is first speaker, 32-N
Raymond Grenfell is new councilor, 33-N
Spleen
subcapsular rupture [Field] *92
Syntex Laboratories
publishes fourth dermatology history, 70-N

T

Taxes
hurricane losses deductible, 489-N
professional dilemma, tax equity through corporate structure [Kennedy] *12
rising beyond belief [Kennedy] 101-E
tougher for American Medicine [Kennedy] 557-E
Taylor, James Marcus
member first Mississippi State Board of Health, biography [Price] *417
Thomas, Danny
named NIH adviser, 35-N
Tobacco
Action on Smoking and Health, a singeing movement [Kennedy] 99-E
Mississippi M.D.'s share Dr. Alton Ochsner's conviction about tobacco's danger [Kennedy] 56-E
Tri-State Thoracic Society
13th annual consecutive case conference, 117-N
Tuberculosis
one-year-old prevention program reviewed by state board of health, 66-N
tuberculous meningitis: a study of general hospital patients in Mississippi [Ricks & Allison] *196
Turner, Charles
serves as AMA volunteer physician in Vietnam, 375-N
Typhoid
Mary Mallon, an ill wind who blew some good [Kennedy] 21-E

U

Ulcer
dumping syndrome, recent concepts [Drapanas] *493
U.S. Department of Agriculture
designates Mississippi as a modified-certified brucellosis area, 114-N
U.S. Department of Defense
orders procedural changes in CHAMPUS drug program [Kennedy] 558-E
U.S. Department of Health, Education and Welfare
Secretary Wilbur J. Cohen not retiring, just moving [Kennedy] 21-E
U.S. Internal Revenue Service
professional dilemma: tax equity through corporate structure [Kennedy] *12
will supply copies of prior year returns to Hurricane Camille victims, 567-N
U.S. Office of Economic Opportunity
will Nixon abolish extravagance? [Kennedy] 512-E
U.S. Public Health Service
cancer survey in cooperation with AAGP, 224-N
National Institutes of Health—Bureau of Health Professions, Education and Manpower Training, awards $32,364,000 to health profession schools, 374-N; funds marijuana growing at Ole Miss [Kennedy] 167-E; National Advisory Cancer Council, Danny Thomas named, 35-N; National Cancer Institute (human tumor cell biology branch established) 76-N, (modular room to provide germ-free environment) 68-N, (virus-cancer reseach booklet published) 230-N, (studies cancer in nuns) 232-N; National Institute of Mental Health, renews MSU alcohol education grant, 532-N
U.S. Senate
no place to grow old [Kennedy] 469-E
University of Alabama
medical center to receive statue of Hippocrates, 67-N
press, publishes Pasteur letters, 533-N
University of Miami School of of Medicine
Division of Otolaryngology, sponsors ENT course, 373-N
University of Mississippi School of Medicine
alumni house nears completion, 565-N
ambulance driver course, 434-N
awards 75 M.D. degrees, 370-N
coronary drug research study with VA, 27-N
County Health Improvement Program, needs health officers, 449-N
courses for rescue personnel, 483-N
Department of Preventive Medicine —slates health care study in Mississippi Appalachian area, 375-N; team completes survey, 489-N
expands pediatric unit, 445-N
faculty, additions and promotions, 116-N, 232-N, 436-N, 520-N
first SMA lecturer, 32-N
Hardy, James D., receives double honors, 231-N
heart transplant performed, 70-N
junior receives SK&F fellowship, 223-N
medical alumni building begun, 378-N
midwifery course, 442-N
Mississippi Postgraduate Institute in the Medical Sciences—to enroll first class, 438-N; opens at medical center, 521-N
Mississippi Regional Medical Program—cancer conferences set weekly, 519-N courses for medical assistants, 578-N; funds Mississippi Postgraduate Institute, 438-N, 521-N; pulmonary seminar, 568-N; sets up pulmonary demonstration, 330-N; stroke unit program (first refresher course) 63-N, (review of first 100 cases) [Maerer *et al.*] *237
nursing building addition, ground broken, 231-N
offers Ph.D.-M.D. degree, 120-N
resident serves as AMA volunteer physician in Vietnam, 375-N
ups class enrollment to 90, 446-N
vice chief is Dr. David Wilson, 562-N
University of Mississippi School of Pharmacy
grows marijuana under federal grant [Kennedy] 167-E

V

Veterans Administration
Jackson hospital and UMC join in coronary drug research study, 27-N
Vomiting
in children, control, clinical comparison of rectal pyrilamine maleate and trimethobenzamide hydrochloride [Tibbs] *130

W

Waites, James C.
sustained in professional liability suit, 119-N
Waites, Thad Fulton
gets SK&F fellowship, 223-N
Waste
State Board of Health research—garbage disposal studied, 78-N; federal funds requested for preparation of statewide disposal program, 119-N; statewide survey of solid-waste problem, 223-N
Williams, M. Ney
heads Gettysburg Memorial Commission, 330-N
Wilson, David
named UMC vice chief, 562
new member, Board of Commissioners, Joint Commission on Accreditation of Hospitals, 110-N
Windham, Thomas L.
awarded Pfizer medical scholarship, 379-N
Woman's Auxiliary
MSMA—46th annual session, 226-N; Biloxi-Ocean Springs Auxiliary, sponsors health careers day, 120-N; Central Auxiliary, donates medical careers film, 330-N
South Mississippi Medical Auxiliary seeks historical information on Forrest County Medicine, 519-N
Wyeth Laboratories
Robert Pearson named field sales manager, 279-N

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar. The asterisk (*) indicates an original article in the JOURNAL.

A

Aldridge, J. E., *191
Allison, F., Jr., *196
Arnold, G. E., 437-BR
Arp, L. J., *412

B

Barlow, J. B., 207-RS
Blake, T. M., *83
Boatwright, C. L., *412
Boronow, R. C., *451
Bowlin, J. W., *331
Burrow, N. R., 242-RS

C

Carr, B., 551-RS
Coffey, J. D., Jr., *37
Currier, R. D., *237

D

Dillon, R. E., *412
Drapanas, T., *493

F

Ferguson, J. V., Jr., 339-RS
Field, R. J., Jr., *92, 563-BR
Flowers, W. M., Jr., *401

G

Gibson, J. Y., 505-RS
Gillespie, G. T., Jr., 437-BR
Gore, A. L., 318-L

H

Haerer, A. F., *237
Hardy, J. D., *83, *283, *535
Hartney, J. B., *244
Heard, K. M., 517-BR
Hester, C. L., Jr., 50-RS
Hickman, B. T., *125
Hutchinson, R. G., *88

J

Jabbour, J. T., *8

K

Kennedy, R. B., *12, 19-E, 20-E, 21-E, 22-E, 53-E, 54-E, 55-E, 56-E, 99-E, 100-E, 101-E, 102-E, 103-E, 165-E, 167-E, 168-E, 211-E, 212-E, 213-E, 257-E, 260-E, 261-E, *291, 313-E, 314-E, 316-E, 317-E, 357-E, 360-E, 361-E, 362-E, 366-BR, 421-E, 425-E, 426-E, 469-E, 470-E, 471-E, 474-E, 475-E, 509-E, 512-E, 513-E, 555-E, 557-E
Kluck, J. J., Jr., *535
Knopf, M. M., *457

L

Langsjoen, P. H., *499
Long, M. T., *412

M

McCay, T. S., *95, *466
McGee, R. R., 487-BR
Marland, T. J., 365-BR
Martin, R. S., Jr., *96
Meek, E. M., 518-L
Mitchell, T. M., 517-BR

N

Netterville, R. E., *503
Nice, C. M., Jr., *201
Nichols, H. H., 563-BR

P

Pankey, G. A., *41
Parker, A. E., *125
Parrish, H. M., *462
Plauche, W. C., 363-L
Price, B. M., *417

R

Rausa, A., *406
Ricks, J., *196
Rogers, J. B., 18-PP, 52-PP, 98-PP, 164-PP, 210-PP, *298
Royals, J. L., 256-PP, 312-PP, 356-PP, 420-PP, 468-PP, 508-PP, 554-PP

S

Scott, E. G., *41
Smith, C., 296-RS
Smith, R. R., *237
Stokes, J. A., 365-BR
Surratt, R. R., 6-RS

T

Tibbs, R. C., *130
Timmis, H. H., *1, *83, *283

W

Watson, D. G., *37, *283
Weems, W. L., *191
White, J. J., 487-BR
Williams, K. O., 410-RS
Wilson, W. B., 43-CPC, 249-CPC, 545-CPC
Woodbridge, J. H., *542

Public Health Association Meets

Mrs. Irene Loftus of Hattiesburg was installed as president of the Mississippi Public Health Association at the final session of the 32nd annual meeting at the Heidelberg Hotel in Jackson.

The district advisory nurse of the State Board of Health succeeds Miss Cleta Brinson of Jackson, who automatically became vice president.

Richard H. Andrews of Jackson was elected president-elect and will be elevated to the presidency at the next annual meeting. He is director of the State Public Health Laboratory.

Some seven hundred members registered for the annual meet in the Capital City. Lt. Gov. Charles Sullivan and MPHA president Cleta Brinson spoke at the opening session. Dr. Hugh Cottrell, state health officer, welcomed the guests.

Sullivan discussed the highlights of the special legislative session which concluded in October.



Mrs. Irene Loftus of Hattiesburg, seated, new president of the Mississippi Public Health Association, was elected at the 32nd annual convention in Jackson. Section chairmen include, from left: Morris Overby, Forest, santitation; Mrs. Mary Butler, Pontotoc, clerical; Dr. William E. Riecken, Jackson, administrative; Mrs. Mary Jane Milam, Charleston, nursing; and Benoit Yelverton, Jackson, epidemiology.

He was introduced by Dr. Frank Morgan, assistant state health officer.

Miss Brinson described the "hallmarks of superiority" which her bosses—all four of the state's public health officers to whom she has been secretary—have set for the rest of the public health workers.

Theme for the convention was "A New Image for Public Health in Mississippi." Twenty-eight public health workers received awards for longtime service, adding to a total of 775 years in public health work.

The second general session featured addresses by Lee W. Schwenn of Washington, D. C., associate director, D. C. Department of Public Health responsible for administration, and Dr. Carl S. Winters, lecturer and minister from Chicago. Schwenn discussed "people, problems, and pieces of paper," relating to the health department and its functions. Winters, a General Motors Corporation lecturer, is billed as a four-star speaker, featuring inspiration, laughter, instruction, and challenge.

Sen. John C. Stennis spoke at the final general session. The convention concluded in specialty session meetings, a business meeting, and election of officers.

Other new officers were section chairmen, elected by the six MPHA Sections. They are: Administrative, Dr. William E. Riecken of Jackson; Public Health Nursing, Mrs. Mary Jane Milam of Charleston; Sanitation, Morris Overby of Forest; Community Health Services, Miss Irene Arnold of Jackson; Epidemiology, Benoit Yelverton of Jackson; and Clerical, Mrs. Mary Butler of Pontotoc.

Medical Assistants Get Training

Central Mississippi medical assistants are adding to their professional knowledge through a four-course series at the University Medical Center. Dr. Ben R. Clower, assistant professor of anatomy at the University School of Medicine, is currently teaching anatomy and physiology, the second 10-week session which began in November.

The classes are open to employees of physicians in Leake, Madison, Hinds, Rankin, Scott, Simpson, Smith, and Yazoo Counties.

The courses are sponsored by the Mississippi Association of Medical Assistants and the Missis-

sippi Postgraduate Institute in the Medical Sciences, a Mississippi Regional Medical Program.

Beginning with medical terminology, the series will conclude with medical law and medical accounting.

1970 Robins Award Is Announced

Announcement was made in November of the Ninth Annual Mississippi State Medical Association-Robins Award for outstanding community service by a physician. The notice was officially sent to the several component medical societies inviting nominations for the singular honor.

The 1970 award will be presented to the winner during closing ceremonies of the 102nd Annual Session on May 14 at Biloxi.

Drs. James L. Royals of Jackson, president, and Mal S. Riddell, Jr., of Winona, chairman of the Board of Trustees, said that each component medical society has been invited to nominate a member for the honor. The award is co-sponsored by the association and the A. H. Robins Co. of Richmond, Va., a long-established maker of ethical pharmaceuticals.

Drs. Royals and Riddell said that nominees must be members of the association and that the community service recognized in the local society's nomination must be separate and apart from purely scientific and professional attainment, since suitable awards in this connection already exist.

Generally, the association leaders continued, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in leadership roles.

Nominations should be made by letter which must be signed by an officer of the local society. There are no restrictions upon length of the letter or attachments which document and support the nominee's qualifications.

Deadline for receipt of nominations at association headquarters is Jan. 31, 1970. Each nomination will be acknowledged, and the Board of Judges, the three vice presidents of the association, will review each nomination.

The award series was instituted in 1962, and eight Mississippi physicians have been recipients of the honor. They are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by the Delta Medical Society in 1967; the late Dr. W. H. Anderson of Booneville, by the Northeast Mississippi Medical Society in 1968; and Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969.

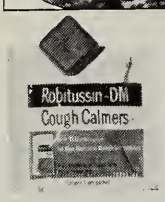
The award is a sculptured bronze plaque in *bas* relief mounted on a mahogany panel with engraved plates.

Rescue Personnel Take Emergency Course



Some 250 Mississippi nonmedical rescue personnel participated in six emergency care courses at The University of Mississippi Medical Center this fall. Part of Project CARE, the workshops offered training in emergency skills and use of equipment to provide better treatment for accident victims. Participants here, from second left, Terrell Trigg and William Carlisle, both of the Hattiesburg Triple A Ambulance Service, and Tom Pardue of Ackerman, Natchez Trace Parkway ranger, are getting instruction on emergency control of bleeding from UMC resident Dr. William O. Bobo (extreme left).



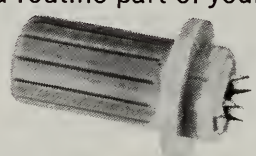


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Index to Advertisers

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Campbell Soup Company 548A

Glenbrook Labs **18A**

Highland Hospital **8**
Hillcrest Hospital **9**
Hynson, Westcott & Dunning **3**

Kay Surgical **7**

Lakeland Nursing Center **10**
Lederle **4, 6, 23,** 562B, 562C
Eli Lilly and Company **front cover, 22A, 22B**

Parke Davis 548D, 562A
Pfizer Laboratories **18D, 19**
Pharmaceutical Manufacturers Association **16**
Wm. P. Poythress 558D

Riker Laboratories **12, 13, 17, 18**
A. H. Robins, Inc. **14A, 14B, 15, 23**
Roche **18B, 18C,** 554A, 554B, 554C, **Fourth Cover**

Sandoz 562D
G. D. Searle 548B, 548C
Smith, Kline and French **11, 14**
Strasenburgh 558A
Stuart Company **second cover**

Wyeth Laboratories **20, 21,** 558B, 558C

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